IN THE DISTRICT COURT FOR CLEVELAND COUNTY
STATE OF OKLAHOMA

THE STATE OF OKLAHOMA, et al., :
Plaintiffs, :
:
VS. : Case No.
: CJ-96-1499L(H)
R. J. REYNOLDS, et al., :
Defendants. :

DEPOSITION OF: CHARLES MERRILL STILES, M.D.
(Videotaped)

DATE: October 29, 1998

TIME: 9:06 a.m.

LOCATION: Law Offices of
Susman, Godfrey, L.L.P.
1000 Louisiana, Suite 5100
Houston, Texas 77002

TAKEN BY: Counsel for the Plaintiffs

REPORTED BY: Susan R. Goldstein Henley, CMR, CRR
Texas CSR #704

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APPEARANCES OF COUNSEL:

ATTORNEYS FOR THE PLAINTIFFS:

NESS, MOTLEY, LOADHOLT, RICHARDSON & POOLE
BY: MS. ALEXANDRA M. WAGNER
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ATTORNEYS FOR THE DEFENDANT LORILLARD TOBACCO COMPANY:

THOMPSON COBURN
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VIDEOGRAPHER:

Mr. Jeff Crawford
Legal Media, Inc.
Houston, Texas

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P R O C E E D I N G S

(Stiles Exhibit Numbers 1 and 2 marked for identification.)

THE VIDEOGRAPHER: Today's date is Thursday, October 29th, 1998. It's 9:06 a.m. We're on the record.

This is the deposition of Dr. Charles Stiles. Our location is 1000 Louisiana, Suite 5100. Our court reporter is Susan Henley with Allied Reporters.

Counsel may now state their name for the record.

MR. COX: James Cox for Lorillard.

MS. WAGNER: Alexandra Wagner with Ness, Motley for the State of Oklahoma.

******

(Nothing deleted.)

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CHARLES MERRILL STILES, M.D.,
having been first duly sworn, testified upon his oath as follows:

EXAMINATION

QUESTIONS BY MS. WAGNER:

Q. Good morning, Dr. Stiles.

A. Good morning.

Q. Could you please state your full name for the record?

A. Charles Merrill Stiles.

Q. Have you ever been deposed before?

A. Yes.

Q. So, you're familiar with the process?

A. Yes.

Q. So, you understand that if I ask a question that seems confusing to you, you can ask me to rephrase it --

A. Yes.

Q. -- if you don't understand it?

Okay. Could you tell me your address, please?

A. [DELETED]

Q. How long have you lived [DELETED]?

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A. Since 1987.

Q. Okay. Could you tell me something about your educational background, let's say starting with college, where you went to college?

A. I graduated from the University of Kansas. I then went to University of Kansas School of Medicine. I then took an internship with the Kansas University Medical Center in internal medicine. I then took two years of training in internal medicine at that same institution. I then took a fellowship in cardiovascular disease.

Q. What was your degree at the University of Kansas, undergraduate?

A. It was a bachelor of arts.

Q. In what?

A. Zoology.

Q. And your internship and residency were both in internal medicine; is that right?

A. That is correct.

Q. And then you had fellowship training in did you say cardiology?

A. Cardiovascular disease.

Q. Cardiovascular disease. Is that a subspecialty of internal medicine?

A. It is.

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Q. What are the other subspecialties of internal medicine?

A. There are many. Hematology, oncology, infectious disease, pulmonary disease, nephrology, intensivists.

Q. What's that?

A. Someone who only cares for people in the intensive care units.

Q. Oh, okay.

A. Critically ill.

Rheumatology, endocrinology.

I'm sure there are others.

Q. Is your only subspecialty within the field of internal medicine in cardiovascular diseases?

A. I also am certified in geriatric medicine.

Q. Now, you didn't name geriatric medicine. Is that also a subspecialty of internal medicine?

A. It is. My lack of naming it was an oversight.

Q. Oh, okay. How long -- now, you have board certification -- what do you have board certification in?

A. Internal medicine and geriatric

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medicine.

Q. So, you don't have separate board certification in cardiovascular disease?

A. I do not.

Q. You do not.

How long have you been board certified in internal medicine?

A. Since 1970.

Q. And in geriatric medicine?

A. I'm not sure of the year. It would be roughly ten years ago.

Q. So, about 1988?

A. Thereabouts.

Q. Okay. Has -- has your lic -- where are you licensed to practice medicine?

A. In Texas and in Kansas.

Q. Can you tell me what years you obtained those licenses?

A. I obtained the Texas license in 1970 and the Kansas license would have been '68.

Q. Okay. Have either of those licenses ever lapsed or been revoked or been suspended for any reason?

A. No.

Q. Okay. How about your board

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certifications, have those been current since the time you first became certified?

A. Yes.

Q. Can you tell me a bit about your academic experience? Have you ever done any teaching?

A. Yes.

Q. Could you describe that for me?

A. I was a clinical instructor at the University of Texas Medical Branch in Galveston for several years.

Q. Can you tell me the dates?

A. Starting in 1970, and I taught actively for several years. I -- I don't remember exactly how long, but say eight or ten years. And I'm still on the staff there, but I'm inactive.

Q. What does it mean for you to still be on staff? What responsibilities do you have at UTMB?

A. None.

Q. None?

And why did you cease to be active in your clinical teaching there?

A. I simply became too -- the demands of the practice that I was in were too great for me to devote that time.

Q. And what was your practice at that time?

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A. Primarily in internal medicine.

Q. Internal medicine?

And where did you practice?

A. I practiced -- the group with which I was affiliated had three offices. We had offices in Galveston, in Texas City and in Friendswood.

Q. Okay. Do you still -- are you still active in those practices?

A. I'm not.

Q. Are you retired?

A. Yes, from the active clinical practice of medicine, I retired in 1972 -- excuse me, 1992.

Q. 1992.

When you say you retired from the active clinical practice of medicine, do you still practice medicine in any regard?

A. I no longer take care of any patients.

Q. Okay. While you were a clinical instructor at UTMB, I think you said it was roughly 1970 to 1978 or '80, thereabouts; is that right?

A. Thereabouts.

Q. Okay. What courses did you teach?

A. I was on the clinical staff that rounded with the students and the house staff. I did not teach any formal courses. The teaching was done at

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the bedside and discussion of various topics would arise as they would relate to the patients that were seen.

Q. What kind of topics?

A. The whole spectrum of internal medicine.

Q. So, that would include medical topics relating to all of those subspecialties you named?

A. Yes.

Q. Okay. Did you -- while you were rounding, did you have geriatric patients that you discussed with the students?

A. Yes.

Q. What percentage of the -- of your patient population were geriatric patients at that time?

A. Is your question relative to my private practice?

Q. No. Let me ask about UTMB first, your teaching.

A. I would have no way of making any accurate judgment about that. It would be the spectrum of ages that were hospitalized at any one time. I would say probably 50 percent or more would be 65 or older, but that would be a --

Q. And you base that upon what?

MR. COX: I'm sorry, Doctor, were you

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finished answering that question?

A. That would be based on the general nature of patients that would be in a hospital. But that's just an estimate on it.

Q. (By Ms. Wagner) Okay.

A. I really don't have any data to answer that.

Q. Okay. Did you maintain any notes or anything from your teaching on rounds?

A. No.

Q. No. So, you don't have -- have you ever taught any formal courses at UTMB?

MR. COX: Let me object to the form of the question in that "formal" is vague and ambiguous.

Q. (By Ms. Wagner) Other than the clinical rounds you just described, have you done any other kind of teaching?

A. There were no occasions where I had a scheduled time to teach in a classroom setting, if that's the gist of your question. The teaching was done, as is a great deal of medicine, at the bedside with a group of students and/or house staff.

Q. Okay. So, did you ever give any formal lectures other than in that setting at the bedside?

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A. As I've stated, I -- I would give what you might form -- might speak of as lectures at the bedside --

Q. Okay.

A. -- but not in a classroom full of a hundred people.

Q. Okay. Or any other classroom size? In a -- you -- did you ever teach in a classroom as opposed to at the bedside?

A. Yes. Often we would retire to a classroom for discussion.

Q. After rounds?

A. Yes.

Q. And what would those discussions relate to?

A. Primarily the patients that we had seen. On occasions there were assigned topics that one of the students would prepare a brief discussion about and then I would lecture regarding that topic and supplement what needed to be discussed.

Q. Did you assign the topics to the students?

A. There were times when I would assign the topics.

Q. What kind --

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A. Other times they would come up as a result of a planned presentation for the next time that we made rounds.

Q. Okay. What kind of topics were presented in these classroom settings?

A. They would span the whole spectrum of internal medicine.

Q. Okay. What percentage of those -- those classroom discussions were devoted to geriatrics, if you know?

A. It would be virtually impossible to answer that question with any degree of accuracy.

Q. 50 percent?

A. It would really be impossible to answer that question.

Q. So, you have no idea?

A. I just don't have any data with which to give you an answer.

Q. Did more of the discussions relate to geriatric patients than to other age patients?

A. I'm not sure how that question's different than the one I just answered.

Q. So, you don't know; is that your answer?

A. Would you restate the question?

MS. WAGNER: Could you read the question

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back?

(The following was read by the Reporter: "Question: Did more of the discussions relate to geriatric patients than to other age patients?")

A. I don't believe it's possible to give a meaningful answer to that.

Q. (By Ms. Wagner) Okay. How do you define "geriatrics," the field of geriatrics?

A. It has to do with conditions and diseases and the state of elderly. "Elderly" is a -- obviously a term that is not clearly defined. There is no agreed upon cutoff point where one begins to speak of someone as being elderly. In general, it's the discussion of people 60, 65 years of age or older, but that is not an agreed upon standard.

Q. Is that the standard that you use when you describe yourself as someone who practices geriatrics?

A. Yes, within the context as -- that I have just said, that it's not a clear definition. If I had someone who was 58, I might include them in my discussion of the elderly, or -- but somebody that

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was 62, I might not.

Q. Okay. Is there an age below which you definitely would not describe the patient as a geriatric patient?

A. Again, there is no rule about that and I -- I don't guess I've ever really thought about that question. I -- I suppose I wouldn't include people below the age of 50.

Q. Okay. You mentioned earlier that pulmonology was a subspecialty of internal medicine; is that true?

A. Yes.

Q. Have you ever subspecialized in pulmonology?

A. By -- what do you mean, "subspecialized"?

Q. Do you consider yourself to have any special expertise in pulmonology?

A. Special in comparison to whom?

Q. Well, I don't see that I -- do you not understand my question?

A. I -- I understand the question, but I don't know what reference point you might be using.

Q. Well, you're board certified in geriatric medicine; isn't that true?

A. That's true.

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Q. Do you consider yourself to have special knowledge in the field of geriatric medicine?

A. Yes.

Q. Do you consider yourself to have special knowledge in the area of pulmonology?

A. I have special knowledge in the area of pulmonology compared to many. There are those who have greater knowledge of pulmonary disease than I and there are those who have taken special fellowship trainings and have become board certified in pulmonary medicine.

Q. And you're not one of those?

A. I am not board certified in pulmonary medicine.

Q. You said that you think you have special knowledge or more knowledge compared to many. Can you explain that?

A. For example, a physician who has been trained to be a general practitioner or who has been trained to be a urologist or other surgical specialties, I think I would have more knowledge than many of those.

Q. And what's the basis for your knowledge in pulmonology?

A. The care of people with pulmonary disease

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is a part of the training and experience and practice of someone in internal medicine.

Q. What do you -- what diseases specifically do you include under the rubric of pulmonary disease?

A. Those diseases that have to do with the lungs and upper airway.

Q. Could you name some of those specifically?

A. I can name some of them. I would make no pretense to be able to name all of them.

Q. Okay.

A. Pneumonia, bronchitis, the common cold, a group of disorders called chronic obstructive pulmonary disease, emphysema, various cancers that involve the lung and lung tissues.

Q. Have you treated patients with all of those diseases?

A. Yes.

Q. How many -- how many patients have you treated who had lung cancer?

A. I would be completely unable to give you any kind of an answer for that. Many.

Q. More than a hundred?

A. Yes, I would think so.

Q. More than 200?

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A. Probably.
Q. More than 500?
A. I -- I don't know. I don't have any data relative to that. Somewhere between 200 and 500, but maybe more. I don't know.
Q. In any given year -- maybe it's easier to think of it this way. In any given year over the course of your career, how many lung cancer patients did you treat, to the best of your recollection?
A. Again, it's not a question I have any data for and --
Q. I understand. Just to the -- your best educated guess would work for me.
A. I would say somewhere between three and six to eight.
Q. And before --
A. Maybe as many as ten.
Q. As many as ten?
And your active clinical practice in internal medicine spanned, if I do the math right, 22 years; is that right? From 1970 to '92?
A. Well, I haven't done the math, but it would have extended actually before that, because I was practicing before 1970.
Q. Oh. You were practicing internal

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medicine before 1970?

A. Yes.

Q. That's just when you were board certified?

A. That is correct.

Q. When did you begin -- did you go -- let me strike that for a second.

Did you go straight through school, medical school, internship, residency and fellowship training, or were there gaps in there?

A. There were no gaps.

Q. No gaps?

So, when did you finish your fellowship training?

A. 1968.

Q. 1968.

And when do you consider yourself to have begun the autonomous practice of internal medicine?

A. Actually, you begin practicing internal medicine when you begin your internship.

Q. But as an intern, you weren't making ultimate decisions with respect to patient care, were you?

A. "Ultimate" is a relative word. We were always under supervision.

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Q. Okay. Were you still under supervision by attending physicians as a fellow?

A. Yes.

Q. When did you begin your practice of geriatric medicine?

I know that you became board certified in 19' -- circa in 1988. When did you start -- do you consider your -- let me stop for a minute.

Do you consider yourself a geriatrician? Is that what -- is that what you'd call yourself?

A. Yes.

Q. Is that a word? Yes?

A. Yes.

Q. And when did you start to consider yourself a geriatrician as opposed to an internist?

A. The practice of internal medicine involves the treatment of the elderly. So, although I would not have perhaps put in the Yellow Pages that I was a gerontologist at the beginning of my practice of internal medicine, the practice and care of the elderly is an integral part of the practice of internal medicine. So, there wouldn't be a day where I could say it was on this day that I began to take care of the elderly, which is really what a gerontologist does --

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Q. Uh-huh.
A. -- is take care of the elderly.
Q. Uh-huh.
A. They are a part of the practice of internal medicine. So --
Q. Okay.
A. In a roundabout way, that's trying to answer the question --
Q. Right.
A. -- to which there really isn't a time.
Q. Right.
Did you -- what was the age breakdown -- and let's start -- let's start in 1968. Did the -- did the average age of your patient population change over time from 1968 to the date of your retirement in 1992?
A. Yes. In 1968, I was taking care of Air Force personnel.
Q. Oh.
A. From 1968 to 1970, I was in the Air Force.
Q. Okay.
A. And the majority of the population were younger people.
Q. And by "younger," you mean under --

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A. Military age.
Q. Okay. So, under --
A. Well, they --
Q. -- 30?
A. Again, they spanned the whole age range, because we did take care of some retirees --
Q. Okay.
A. -- but, in general, it was a younger group of people.
Q. Okay.
A. Then when I started practicing in 1970, in Galveston, then the population would have been -- there would have been many -- a much higher percentage of the people who were older, and that really would have basically maintained itself throughout my years of clinical practice --
Q. That percentage breakdown --
A. I hadn't quite --
Q. -- from 1970 on?
A. I hadn't quite finished the answer.
Q. I'm sorry.
A. I -- I hadn't really ever analyzed this, but I suppose by virtue of the fact that I was particularly interested in the care of the elderly, that perhaps even during -- from 1970 to 1992, there

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may have at some point in time began to be some shift in my practice as opposed to the doctor down the street that I might have taken care of more elderly patients than they did just by virtue of word of mouth, reputation.

Q. And when did you say that shift occurred?

A. I didn't say because I don't have any way of knowing, but just --

Q. Okay.

A. -- in general, I would think that just the way practices develop that perhaps word of mouth, it would seem likely that I probably took care of a larger percentage of the elderly in the location which I was located than, say, the average internist.

Q. When you say -- I know we tried to define -- or we did try to define "elderly." Tell me again what your definition of "elderly" -- the age breakdown for -- the age cutoff for elderly is? Just the way you use it. I know that you said there was no generally agreed upon consensus, but if I could understand the way you're using the term.

A. In general, around the age of 60 and above, plus or minus.

Q. Okay. Since you moved to Galveston and

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started private practice in 1970, what percentage of your patient population was 60 or above?

A. I would have no data upon which to base an answer for that. I would say it was probably more than 50 percent.

Q. More than 50?

Do you think it was more than 60 percent?

A. It could have been. I really don't have any way of judging that.

Q. What about more than 75 percent?

A. Possibly.

Q. Possibly more than 80 percent?

A. I don't believe I could go further than I've already gone.

Q. Okay.

A. And be accurate.

Q. Okay. Now, if I understood you correctly, I think you said there may have been a shift in the age -- the age breakdown of your patients over time just because of the way that practices develop and maybe by word of mouth you got more referrals of older patients; is that true?

A. I said that's an assumption, but it seems like that that's probably occurred.

Q. Okay. From the time that you started --

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that more than 50 percent of your patients were elderly patients, what do you think the average age of the patients that you were treating was?

Do you understand my question?

A. No, I don't.

Q. Would it be possible for you to tell me what the average age of your patient has been just over the course of your career? Or how about, instead of average, average seems kind of meaningless, how about the median age of your patient population?

A. I would -- I would have no idea. I don't -- I don't know how in the world I would ever come up with even a rough estimate.

Q. What has the male/female ratio been of your patient population over the course of your career?

A. Well, I've never thought about that question, but I would think it would be more likely than not that there were more females than males.

Q. On what are you basing that statement?

A. One, males tend to go see a physician less than females. And, two, women tend to outlive men. And, therefore, in the elderly population, there would, of necessity, be more females than men.

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Q. Why is that, in your medical opinion, that women tend to outlive men?

A. It's undoubtedly a multi-factoral cause of which we do not know.

Q. Do you know any of the factors involved?

A. At least one factor would likely be that they do tend to seek medical care more than men. I'm not -- at the moment I'm not aware, I don't recall any studies analyzing the why of the -- of the fact that women tend to outlive men.

Q. Do you know whether women generally tend to lead healthier life styles than men?

MR. COX: Well, let me object to the question as being vague as to what is meant by "healthier life styles."

Q. (By Ms. Wagner) Do you know what I mean by "healthier life style?"

A. Could you define that?

Q. Someone who exercises more, eats less fat, doesn't smoke, any of those things. Do those healthier life style choices seem to predominate in women more than men?

MR. COX: I'm going to object to the form of the question in that it assumes that those are, indeed, healthier life styles.

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A. So, could you restate the question?

Q. (By Ms. Wagner) Why don't I break it down.

Do you know whether or not women tend to eat less fat than men?

A. I'm not sure that I know the answer to that.

Q. And again, I'm talking about elderly women over the -- and -- over the course of their lifetime. So, do you know whether women who are elderly today over the course of their lifetime would have eaten less fat or cholesterol than the same aged man? That's basically my question.

MR. COX: Objection. Compound.

A. So, in an attempt to try to make sure I understand the question, your question is: As a group of people, do same age elderly women, have they historically eaten a diet containing less fat than same age elderly men? Is that your question?

Q. (By Ms. Wagner) Right. Right.

A. I don't know the answer to that question.

Q. What about same question, but instead of eating fat or cholesterol, smoking?

A. So, your question is: In same age

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elderly men and women, over the course of their lifetime do I know whether the women have smoked more or less?

Q. Right.

A. No, I don't know.

Q. Would you say that over the course of your career you've treated -- your patient population has been more than 60 percent female?

A. Again, I have no data on which to make an accurate judgment, but I would suspect that that's true.

Q. Over 60 percent?

A. Probably over 60 percent.

Q. Over 70 percent?

A. Possibly.

Q. Over 75 percent?

A. Possibly.

Q. 80?

A. Well, perhaps it's as high as 80, but I would certainly be less certain of that and I -- and I doubt if it would have been more than 80.

Q. Okay. Since you started private practice in Galveston in 1970, what has the racial composition of your patient population been?

A. Well, there would have been Caucasians --

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Q. What percentage, if you can make a good guess?

A. Well, I can make a guess. I wouldn't know whether it was accurate within a great percentage range because that would not have been data that I would have kept even at the time.

Probably between 50 and 70, 75 percent Caucasian. Blacks, maybe 15 to 25. And --

Q. 15 to 25?

A. Possibly.

Q. Okay.

A. And I know these may or may not add up to be 100 because I'm not --

Q. That's okay. I know you're giving me ranges.

A. -- I'm making no attempt to do the math in my head.

Q. Okay.

A. Hispanics, probably 10 to 20 percent.

Q. Okay.

MS. WAGNER: Can we take a break?

THE WITNESS: Suits me.

THE VIDEOGRAPHER: 9:46 a.m. We're off the record.

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(Recess taken.)

THE VIDEOGRAPHER: 9:52 a.m. We're on the record.

Q. (By Ms. Wagner) Dr. Stiles, do you know anything about the demographics of the nursing home population in Oklahoma?

A. Yes.

Q. Can you tell me what you know?

A. They are about 70 to 80 percent white, Caucasian, and about 10 to 15 or 5 more percent black, about roughly 5 percent American Indian and 5 or 10 percent other.

Q. And what's the basis for your knowledge about that?

A. There -- I've seen some figures relative to the nursing home part of the -- to that type of question from materials that are in my bibliography.

Q. Are those materials that you found as a result of a literature search that you did yourself?

A. No.

Q. Who provided you with those materials?

A. Mr. Cox.

Q. And can you tell me when Mr. Cox provided you with those materials?

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A. Not precisely. Around July, I believe, of this year.

Q. Do you remember which reports or articles specifically contained those figures?

A. No, not right off I don't.

Q. But everything that you've read that contains such figures is in -- is in this disclosure?

A. May I see what you're referencing?

Q. Sure.

MS. WAGNER: Handing the witness Exhibit 2.

A. Would you mind now restating the question?

Q. (By Ms. Wagner) My question was whether all the materials that you've read that contain the figures relating to the racial composition of the nursing home population in Oklahoma that you just cited for me, whether all the materials that contain those figures that you're familiar with are actually listed on that disclosure?

A. Yes.

Q. Okay.

A. And the numbers that I have given you I don't claim to -- that they are accurate to a percentage point.

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Q. Oh, I understand.

A. They're just sort of my general recollection --

Q. Right.

A. -- of the -- of the breakdown.

Q. Right.

A. I mean --

Q. I'm just trying to make sure you're not relying on any other documents not contained in that disclosure for the -- for this information.

A. For that -- for the information that we just discussed relative to the breakdown of racial distribution of the nursing home population in Oklahoma, that's true.

Q. Exactly. Very good.

Can you tell me what you know about the male/female ratio of the nursing home population in Oklahoma?

A. I have read some percentages and as we speak, I'm not -- I wouldn't want to say with certainty that the figures that I have read break -- relate to nursing home populations or whether to the general population, but I believe the -- in the elderly population the ratios are in the range of more females than males and it seems to me I read a

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figure of I want to say 60/40, but I -- I could be off slightly. But I'm fairly certain I read a number that indicated that there were clearly more females than males, but that may have related to the population in general as opposed to just the nursing home population. I'm not certain of that.

Q. General population among elderly or general population overall?

A. Again, I wouldn't want to say absolutely. My recollection is that it was among the elderly --

Q. Okay.

A. -- but I -- I could be wrong about that.

Q. Do you know whether the articles that you recall reading are contained in that CV?

A. Yes.

Q. What do you know about the average age of a nursing home resident in Oklahoma?

A. I'd have to think about that. I'm not -- a number doesn't come to mind right off, but given some time, I might -- I might think of that.

Q. Have you read anything about that?

A. It seems that I have, but I wouldn't want to misquote myself, so I'm reluctant to -- to make a statement.

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Q. If you have, would those materials also be listed on your disclosure?

A. As relates to Oklahoma?

Q. Right.

A. Yes.

Q. How do the demographics -- and when I say "demographics," I'm referring now to race, gender and age -- the demographics of the nursing home population in Oklahoma differ, if at all, from the national nursing home population?

MR. COX: Doctor, if you need to refer to any of your materials, they are here and available to you.

THE WITNESS: Okay.

A. With regard to age, I believe the Oklahoma population has tended to be slightly younger than the national average.

With regard to race, I think they are within the ballpark primarily of the national averages.

And, as I stated earlier, with regard to sex, I'm not -- I don't at this moment recall exact numbers as to whether they were nursing home populations or general populations in terms of the distribution, but I don't believe there's a

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significant disparity between the Oklahoma data on that as opposed to the national.

Q. (By Ms. Wagner) And what do you -- what do you base your opinion on?

A. Materials contained in the bibliography plus my general knowledge of national data.

Q. Okay. Have you ever conducted any studies yourself of nursing home populations?

A. By "studies," I assume you mean some type of scientific investigation?

Q. Right.

A. No.

Q. Have you ever practiced medicine in Oklahoma?

A. No.

Q. Have you ever treated a patient in Oklahoma?

A. Not in Oklahoma, no.

Q. Have you ever visited a nursing home in Oklahoma?

A. No.

Q. How, if at all, does the nursing home population in Texas compare with the Oklahoma nursing home population, again with respect to the demographic parameters that we've talked about?

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A. There would be fewer American Indians by small percentages because there are not -- there's not a great percentage even in Oklahoma, and there would be a larger percentage Hispanic in Texas because there's a larger percentage of Hispanics in Texas.

Q. What about with respect to age or sex? And I know you said that with respect to gender, you weren't sure about the data that you were familiar with in Oklahoma. But do you know how they compare, the two populations in Texas and Oklahoma compare on those two, age and gender?

A. Again, I think the -- as I recall, the age tended to be somewhat younger in Oklahoma.

Q. When I asked you earlier, Dr. Stiles, about the number of lung cancer patients you treated over the years, you thought maybe up to ten a year you had treated. Do you know of those how many were nonsmokers?

A. I would have no data whatsoever on that.

Q. Do you take medical histories when you first see a patient?

A. Yes.

Q. Do you ask this patient's smoking history as part of that medical history inventory?

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A. Yes.

Q. Do you know offhand or your best guess whether more than half of your lung cancer patients were smokers versus nonsmokers?

MR. COX: Let me object in that the question is asking the witness to guess. He's not required to guess about anything. If he has a best estimate or an estimate, he can give that, but this is not the arena by which we guess at answers.

A. Would you restate the question?

Q. (By Ms. Wagner) To the best of your knowledge, do you know whether more than half of your lung cancer patients were smokers versus nonsmokers?

A. As I've previously stated, I really -- I would have no data relative to that. I'm just trying to think if there's any way I would know the answer to that and I -- I really wouldn't know the answer to that.

Q. Why is it important to know whether a patient is a smoker or a nonsmoker?

A. With regard to?

Q. Well, why do you ask the question when you first see a patient? Why is it part of the medical history?

A. Smoking has statistically been associated

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with certain diseases and it's for that reason that we ask the question.

Q. Do you ask as well -- do you inquire whether the patient was a former smoker as part of the smoking history question?

A. Yes.

Q. Why is that important to know?

A. For the same reason that I've stated about current smokers.

Q. And what was that again? I'm sorry.

A. That there has been a statistical association of smoking population as a risk factor as relates to certain diseases.

Q. Can you name the diseases for me?

A. Name the diseases --

Q. With which smoking has been statistically associated as a risk factor?

A. I can name several of them. I don't know whether it will be an exhaustive, all-encompassing list, but --

Q. I understand.

A. Statistically as a risk factor in population studies, smoking has been associated with cancer of the lung, cancer of the larynx, cancer of the oral cavity, cancer of the esophagus, cancer of

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the stomach, cancer of the bladder, cancer of the bowel, cancer of the pancreas, cancer of the cervix. And there may be others.

Smoking has been in statistical epidemiology studies shown to be associated with as a risk factor for various vascular diseases, such as coronary artery disease, peripheral vascular disease, carotid atherosclerosis, atherosclerosis of the aorta, and similarly a risk factor for chronic obstructive pulmonary disease, similarly as a risk factor for low birth weight deliveries and some other conditions of pregnancy.

I'm sure there's others, but those are the ones that primarily come to mind at this time. Given more time, I might think of some additional ones.

Q. Okay. When you say "risk factor," what do you mean by "risk factor"?

A. In epidemiology studies of populations, certain conditions or life style habits have been studied as they are associated with certain diseases and when there seems to be a statistical association, then we speak of that condition or life style as a risk factor for that particular disease.

Q. What is relative risk?

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A. Relative risk is a statistical phrase that has to do with taking a group of people, a number of people who have a certain risk factor and dividing it by a similar group of people who do not have the risk factor. I believe that's how one arrives at the relative risk.

Q. Is it also an expression of how likely a certain population is to develop a certain disease?

A. Well, populations don't develop diseases. Individuals develop diseases. So, I think it's an expression of what I've just said. It's a -- it's a ratio.

Q. And what does it mean, what does it tell you if someone has a relative risk of 2.0 of developing a certain disease? What does that mean?

MR. COX: Let me object to the form of the question in that it misstates prior testimony. I believe he just stated that individuals -- or those are relative risks of populations.

But you may try to answer.

A. Would you restate the question?

MS. WAGNER: Could you read it back?

(The following was read by the Reporter: "Question: And what does it mean, what

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does it tell you if someone has a relative risk of 2.0 of developing a certain disease? What does that mean?")

A. Well, for an individual, it doesn't -- it has no meaning.

Q. (By Ms. Wagner) What about for a population?

A. For a population, if you're talking about in a -- in a -- again, in a statistical analysis as a risk factor, then a number of 2.0, or whatever it was you said, states that there is a greater risk in that population for the development of a certain condition under study if they -- if they have the life style or condition under study as opposed to those who do not.

Q. And what does that mean for that population to have a 2.0 relative risk? Does that mean they're twice as likely to develop the condition as people outside of the population?

A. I'd have to think about that. I'm not -- I'm not -- I don't think that's correct, but I'm not a -- not a --

Q. Okay.

A. -- Ph.D. in statistics --

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Q. Okay.

A. -- so I'm not really sure about that.

Q. Have --

A. I know it's, as I've stated, it indicates a -- for that particular factor a greater risk, but I'm not sure that the answer is that that equates with twice. I don't think so.

Q. Okay. Do you consider yourself an epidemiologist?

A. Well, I don't have a Ph.D. in epidemiology or I've not taken a fellowship in epidemiology. I have some knowledge about the nature of epidemiology and the nature of those studies.

Q. What's the basis for your knowledge about epidemiology?

A. As a part of our training as physicians, we are -- we take a course in epidemiology. And then throughout the career of a physician, we are -- the literature is filled with various kinds of epidemiological studies.

Q. And you've kept abreast of that literature over the course of your career?

A. I continue to keep abreast of medical literature.

I guess I should qualify that.

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Obviously, no one can keep abreast of all of the medical literature.

Q. Sure.

How is it that epidemiology is relevant to your clinical practice in treating patients?

A. Physicians are interested in the relationships in populations of different diseases and different life style choices or conditions and how they seem to be associated with or not associated with certain diseases. One of the interests, of course, would be in terms of seeing if there are ways to make an impact in populations of alterations of life styles, for example, to see if those alterations would have anything to do or would bring about a change in the population.

Q. I'm sorry. In the population or in the -- in the patient that you're treating?

A. Well, you asked about epidemiology studies.

Q. Right. I was asking how it is that keeping abreast of epidemiology informs -- impacts your clinical practice. Your treatment of individuals is what I mean by "clinical practice."

A. Well, we're -- we're interested in anything that we can learn from epidemiology studies

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that might be used in a way to be helpful or therapeutic when applied to individual patients or groups of individual patients.

Q. So, you recommend -- on the basis of the epidemiology that you've read, you recommend certain behavior modification to your patients?

A. Well, I recommend behavior and life style modifications to my patients and some of the basis for that might be on the basis of epidemiology studies.

Q. Okay.

A. There may be other factors involved, but that could be a factor, yes.

Q. Okay. What can -- what kind of life style and behavior modifications do you recommend to your patients that they make?

A. Relative just to the world at large or any specific --

Q. Just your patients in general, what type of advice do you give them about their life style and behavior?

A. Well, it's difficult to make sweeping generalizations of that nature because the patients are treated one at a time and, so, what advice I might give to one person might be different than the

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next and so forth. So, I --

Q. Uh-huh.

A. -- it's a little bit broad for me to try to answer.

Q. Uh-huh. Do you ever recommend to your patients that they take up smoking?

A. I can't recall ever doing that, no.

Q. Do you advise to your patients that they stop smoking?

A. Yes.

Q. And in -- do you advise all your smoking patients to stop smoking?

A. I can't think of an exception to that. There might have been --

Q. Okay.

A. -- but I can't think of one.

Q. And what's the reason for that?

A. As we've already discussed, it has been shown that in epidemiology studies, at least, smoking is a risk factor associated with certain kinds of disorders.

Q. Does smoking cause lung cancer?

A. Well, it depends on how you -- to my way of thinking, it -- the -- that has not been demonstrated.

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Q. What percentage of lung cancer patients in the general population are smokers, if you know?

A. Did you ask --

THE WITNESS: Could you read the -- read that back?

(The following was read by the Reporter: "Question: What percentage of lung cancer patients in the general population are smokers, if you know?")

MR. COX: Let me first object to the question in that it is vague as to whether you're talking about cancer of the lung or cancer in the lung.

But you may answer.

A. If we are confining ourselves in that question to cancers that have had their origin, parent origin --

Q. (By Ms. Wagner) Right. I'm not talking about metastases to the lung.

A. With that qualification, I cannot right off give you an exact percentage, but the majority of people diagnosed with having lung cancer have, at

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least at one time or another, been smokers.

Q. When you say "majority," do you know whether that's an 80 percent majority or higher?

A. I -- I'd be reluctant to give a real specific percentage because I'm not absolutely sure of that, but I would say it's probably more than 70 percent, could be -- could be higher than that.

Q. So, you don't know whether it's 90 -- could be 90 percent?

A. I'll say it's somewhere between 70 and 90.

Q. Okay.

A. But I could be off 5 percent.

Q. Okay. And what do you base that on?

A. General knowledge.

Q. What percentage of your patients over the years have been nursing home patients?

A. Well, it would really be impossible for me to give you a percentage number that would have any meaning because I couldn't even -- I couldn't give you an accurate estimation of how many patients I was responsible for in any one year. We just didn't keep that kind of data.

What I can say is that I attended at a number of nursing homes in the area and had varying

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numbers, but significant numbers, of patients in those homes during a large portion of my practice time.

Q. When you -- when you say you attended nursing homes in the area, what do you mean by attended them? What did you do there?

A. "Attended" is a term that is used in medical circles to indicate cared for patients.

Q. You were an attending physician there?

A. I was the attending physician for individuals in the nursing home.

Q. Now, are these patients who were your patients before they went into the nursing home or did you ever -- well, let me just ask that first.

A. Some of the patients that I cared for in nursing homes were -- had been prior patients of mine.

Q. What about the others? How did you come to be their physician?

A. Some of them were not prior patients of mine who would come to a nursing home who did not have a physician at all or didn't have a physician who was in the area or didn't have a physician who was in the area who took care of patients in nursing homes.

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Q. And how did they -- how would those patients hear of you?

A. The -- as a practical matter, they would -- either the family or the patient would know of me through knowledge in the community, although they were not a patient of mine, or they would arrive at the nursing home with no knowledge of who took -- who cared for patients in the home and they would then have to seek that information out and that information would, in the usual course of events, be supplied by someone at the nursing home, the administrator, one of the nurses, the director of nurses or someone who was a point contact for the family -- between the family of the person that was going in the nursing home.

Q. Now, was this some kind of formal referral arrangement you had with the nursing homes or was this purely informal word-of-mouth type of referral?

A. Well, I'm not sure what you mean by the word "formal." The way it worked was as I have described. Not all physicians in any geographic area care for nursing home patients at all and in any one home, only certain physicians care for patients in that home. So, it's a finite universe of physicians

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who are really available to care for persons in any one nursing facility.

Q. Were you -- which homes, if any, were you specifically affiliated with, where you were one of the list of physicians who treated patients in that home?

A. There was a home in Galveston. There was a home in --

Q. Can you give me the names, if you can remember?

A. I -- I can't remember the names of most of them and part of that problem is that the names changed both during my practice and subsequent to that.

There was the -- the home in Galveston --

Q. If you can come up with an address, that would be better than nothing.

A. -- was -- I believe it was called Moody Geriatric Center, I believe was the name, at least at one time.

And then there was a home -- early on there was another home in Galveston, just for a few years, not -- and I have no idea -- it was a rather small home and I have no idea what it was called and it no longer exists and I don't recall even where it

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was, but it was on the island.

And then there was a -- there was a home on the -- on the Gulf Freeway and I -- I'm not certain whether its address would have been La Marque or Texas City, but it was on the Gulf Freeway and at one time it was called Manor Care.

Q. Manor Care?

A. Uh-huh.

Then there was a home just off of Highway 3 near what was then called Mainland Center Hospital and I don't recall it -- what it was called.

Q. That's in Texas City?

A. That would have been in Texas City.

And then there was a home in Friendswood on FM 18 or 19. I believe it was called Friendswood Nursing Home.

Q. What was 18 or 19? Sorry.

A. FM 18 --

Q. Oh, FM 18 or 19.

A. Yeah.

Q. And --

A. There was one other home --

Q. Okay. Sorry.

A. -- and again, La Marque and Texas City's boundaries were not a straight line and I'm not sure

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whether its address was Texas City or La Marque, but there was another nursing home in that area where I attended.

Q. When did you first start attending at nursing homes?

A. Well, I believe that started right away after I started practicing in Galveston. I was a part of a group and my recollection is that there were patients there in a nursing home that I began to see as patients fairly soon after I started practicing.

Q. So, the early seventies?

A. Well, it would be the late seventies because I started practice in July. So, sometime during the latter part of 1970.

Q. By the late seventies?

A. Late 1970. Late 1970.

Q. Right.

A. Okay.

Q. Oh, late 1970.

A. 1970. I started practicing in July of 1970 --

Q. Oh, in 1970. Okay.

A. -- so it would have been sometime --

Q. Okay. Late 1970.

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A. -- in the latter part of 1970.

Q. Okay. Got you.

What percentage of the time -- of your time as a practicing physician was devoted to the care of nursing home patients versus patients that came to see you in your offices?

MR. COX: Let me object. Vague as to time.

Q. (By Ms. Wagner) If it changed over time, you can tell me that, but we'll just start at the beginning.

A. Well, the answer to the change over time is that it -- the amount of time would have grown. The number of physicians who attended in the homes was limited and, so, one's reputation, I guess you could say, grew over time. So, I would say the amount of time grew over time.

Q. Okay.

A. And I -- I couldn't really give you an answer of the amount of time in terms of a percentage, but to try to give some idea about that, I could say the following: That I would see the patients on average once every month or two. I would see them when needed, on an as-needed basis, but, in general, I would make rounds and see all the patients

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in any one home every month or two.

Q. So, that would be one day out of the month that you would go to one of the nursing homes?

A. That is correct.

Q. Did you go to every one of the six that you named every month?

A. There wasn't any set routine like that and it wouldn't take all day. It usually would not take even a half day.

Q. What wouldn't? To see all the patients in any one nursing home?

A. Right.

Q. So, it wouldn't even take half a day?

A. Usually not. So, I -- I suppose you could go through and do some sort of a mathematical formulation of that relative to how many half days there are in a month, but I have not done that and I certainly won't attempt to do that in my mind. But, in general, that's the way that would work.

There would then be times when because of a change in -- acute or sub acute change in the condition, I would go see an individual patient on an as-needed basis, and that would happen from time to time. On some of those visits, since I was there, I might then see maybe a handful of patients just

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because of my presence there and the nurse might have some questions.

Q. Uh-huh. Uh-huh.

A. So, there weren't any --

Q. How often would that happen where you needed to go in for some kind of acute or sub acute care on an individual patient? Would that happen once a month that that would -- kind of situation would arise or less?

A. I would say, in general, around once a month. Sometimes it seemed more often, but probably not much less often than that.

Q. How did you become -- how was it that you became one of the exclusive physicians who treated nursing home patients in the six nursing homes that you named?

A. I would not want to label myself as an exclusive physician, so let me take that out of the question, if I may.

Q. Well, didn't you say that these six hospitals had a finite list of doctors that they referred their patients to and that treated their patients?

A. That is a -- that is correct --

Q. Is that true? Okay.

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A. -- but the word "exclusive" has -- could have numerous connotations, so I would object to the word -- use of the word "exclusive" in this context.

Q. Okay. How did you become one of the ones on the list?

A. By availability and willingness to attend at the homes.

Q. So, you went to the homes and told them that you were available and willing? Or how did that work? How did you communicate your availability and willingness?

A. I don't recall ever doing exactly what you described. I honestly don't remember exactly how that came about, but I remember that it was not that I went to the home and said, "I would like to start taking care of patients here."

It may have been by phone call inquiring whether I was willing. Or the situation would arise perhaps in the very beginning where I had a patient of mine who wanted to go to a particular home and that may have then triggered a sequence of events where I became a part of that cadre of physicians who were willing to go to that home. I don't -- I don't really recall how it came about.

Q. Were there any other homes besides those

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six that you listed where you treated patients?

A. I didn't keep track of the count. As we speak today, I don't recall any other homes --

Q. Where you treated --

A. -- where I treated.

Q. Okay. Did you treat patients in those homes on the list from 1970 to 1992? Did you have patients in every one of those homes that you treated?

I know you mentioned that one of them was only in existence for a few years, so it obviously can't have been true that you treated patients for 22 years at that one.

A. That's right and that's obvious.

Q. Do you know which -- you said that was another Galveston home and it was in existence for a few years. Do you remember what the time frame was there that you treated patients there?

A. No, I don't --

Q. You don't.

A. -- but it wasn't for a long period of time. I would say in the range of four or five years, give or take two or three years. But it was a relatively short period of time.

Q. And was that in the 1970s or the 80s

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or --

A. I don't believe it -- I don't believe it was in existence for as long as ten years. It would have been something less than ten years.

Q. Right. But that two- to five-year period where you treated patients there, what decade was that?

A. That would have started in 1970.

Q. Oh, okay. So, about 1970 to '72 or '75.

A. And then the other homes, the home in Friendswood only came into existence during the latter period of time that I cared for patients in a nursing home and I don't remember exactly when that would have been, but somewhere around maybe 1985 to '88, somewhere in there.

Q. That's when it came into existence?

A. Somewhere in there. I'm not --

Q. Okay.

A. -- I'm not sure exactly.

Q. And you continued to treat patients there until you retired in '92?

A. No. Sometime prior to my retirement, I elected to discontinue practicing in the nursing homes, all of the nursing homes.

Q. When was that?

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A. I don't -- I don't remember precisely, but it was probably around 1990.

Q. Okay. Why was --

A. Maybe a little earlier than that.

Q. Okay.

A. But in that ballpark. It could have been even '91, but I think around 1989 or '90.

Q. Okay. And did you stop all of them at once, your practice in all of those nursing homes at once?

Were you practicing --

A. No. I moved from Galveston to the mainland in 1987 and --

Q. To Houston or somewhere else on the mainland?

A. Well, it is a Houston address. It's in a subdivision called Clear Lake.

Q. Uh-huh.

A. South of --

Q. Yeah, I know.

A. -- Houston proper.

And sometime after that, because of the driving distance, I discontinued seeing patients in the Galveston nursing home.

Q. Okay. And then two years later -- by

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about two or three years later you had ceased seeing patients in the other nursing homes?

A. Yes. Something in that order of magnitude, yes.

Q. Now, why was it that you elected to stop seeing nursing home patients? Well, you -- I'm sorry. Go ahead.

A. Nursing home practice is in some ways a very demanding practice. It requires an enormous amount of paperwork. And I made the determination that I simply was no longer able to carry that burden.

Q. Okay. I hate to belabor the point here, but I'm really trying to get a good picture of your practice. We've kind of pegged down the -- did you work in the Friendswood nursing home until about '89 or '90 when you ceased your nursing home practice?

A. With the exceptions that we've discussed, the early on nonexistence of the small nursing home in Galveston --

Q. Uh-huh.

A. -- and the exception of discontinuing my nursing home practice in the other nursing home --

Q. Uh-huh.

A. -- in Galveston because of a change of

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residence --

Q. Right.

A. -- then I discontinued my nursing home practice in the other homes all at approximately the same time.

Q. Okay. And when did you start -- did you start all of your nursing home practices in 1970?

A. No.

Q. Which ones were later than 1970?

A. The ones on the mainland.

Q. The ones on the mainland. So, Moody, if that's the right name, would have been 1970?

A. Yes.

Q. So, Manor Care on the Gulf Freeway either in La Marque or Texas City would have been later than 1970?

A. Yes.

Q. Do you know how much later?

A. Probably by a year or so.

Q. So, about 1971.

And the one at --

A. And that would have been true for all the other ones I named.

Q. '71?

A. Yes.

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Q. Okay.

Okay. And if I can just sum up. You might have been -- if I can do the math, you might have been treating patients in a nursing home between one and three days a month from the time you started until the time you ceased your nursing home practice? Is that fair?

MS. WAGNER: I'm sorry. Did I say one to three days?

THE REPORTER: Yes, ma'am.

Q. (By Ms. Wagner) Okay. That's what I meant.

A. Well, you said you have done the math. I have -- I have not done the math --

Q. Well, I'm just looking at --

A. -- but I would think it would have -- I doubt if it could have been done in a -- in a day.

Q. Okay. That's fair. So, maybe two, two to three?

A. Well, I'm even hesitant to say it could be done in as little as two days, but again, I -- that's --

Q. Is it possible that you spent only two days on occasion per month with your nursing home patients?

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A. I suspect in most months the total amount of time would have been more than -- if you say a day is eight hours, I think it would be probably more than that, but maybe not on the average by a lot more than that. And then there would have been months where it would clearly have been more than that and maybe as much as four or five days.

Q. Okay.

A. But again, I would want to preface those additions with all the remarks that I've made about --

Q. Sure.

A. -- I just -- I can't really say with --

Q. That's fair.

A. -- any accuracy much greater than that.

Q. Okay.

MS. WAGNER: This would probably be a good point to take another five-minute break --

MR. COX: Okay.

MS. WAGNER: -- if that suits you guys.

THE VIDEOGRAPHER: 10:54 a.m. We're off the record.

(Recess taken.)

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THE VIDEOGRAPHER: 11:04 a.m. We're on the record.

Q. (By Ms. Wagner) Okay. Dr. Stiles, were all of your geriatric patients in the nursing homes?

A. Oh, no.

Q. No?

A. No. I cared for many elderly patients that were not in nursing homes.

Q. Do you define "geriatric" and "elderly" the same way? Are those synonymous?

A. Well, under the broad definition of -- that we've discussed about the age --

Q. Yeah.

A. -- yes.

Q. Okay. I just wanted to make sure.

How many patients did you have in each of the homes that we talked about in any given year?

A. Well, that would be very difficult to answer accurately also. A, it varied. I would -- in the -- it would vary some from home to home. In the Galveston home, I would say somewhere between five to 15 or so at any one time.

Q. That was in the -- the Moody Galveston home?

A. The Moody Geriatric Center.

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Q. Uh-huh.

A. On the one that was at one time called Manor Care on the Gulf Freeway, from maybe ten to as many as 30, or maybe even slightly more than that during certain periods of time. And, likewise, the other home that's in the Texas City/La Marque there, that could have been anywhere from ten to maybe 40 at any one time. And then the one next to the Mainland Center Hospital, more like maybe ten to 30, there might have been times as many as 40.

Q. And that leaves Friendswood.

A. And Friendswood would have been more like five to ten.

Q. And the average age of the nursing home patient, was that older than the average age of your elderly patient that you saw in clinic -- or in your practice, office practice?

A. Well, possibly. Certainly the nursing home population tends to be in their seventies and up with lots of them in their eighties.

Q. Are most of them in their eighties?

A. Certainly the majority would be 75 and above, with many, many of them being in their eighties. But I did take care of a fair number of patients in the office that were likewise elderly.

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So, that would be hard to --

Q. Right. I'm just trying to --

A. -- hard to say.

Q. -- get a contrast.

A. I guess overall the nursing home patients were probably on average in the geriatric age group a little older than those in the office.

Q. Five years older or ten years older?

A. No, I wouldn't say as many as ten.

Q. You wouldn't?

A. Because I took care of a large number of people who were in their seventies and eighties in the office.

Q. So, maybe the average age of your nursing home population might have been up -- about five years older than your -- than your geriatric --

A. I just --

Q. -- patient?

A. -- I don't believe I can go further than I've said. I couldn't put a number on that. I just -- I would think there would be a tendency for them to be somewhat older, but --

Q. Less than ten years?

A. Yes, certainly less than ten years.

Q. Comparing the number of your geriatric

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patients that were in nursing homes to the ones you treated in your office, were you treating about the same number of geriatric patients in and out of nursing homes or were you treating twice as many in the office as you were in the nursing homes? Can you give me some kind of idea of how they compared?

A. Well, that would be very difficult. I've never really thought about that. I would think that the numbers, absolute numbers of those over 60 or 65 cared for in the office would be greater than those cared for in the nursing home. Is that --

Q. Okay. Would be greater?

A. I would think so.

Q. You don't know if it was double?

A. I would have really -- I'm stretching it to even say that it was definitely greater.

Q. Okay.

A. And I can't say definitely --

Q. Okay.

A. -- but I would think just in virtue -- by virtue of the differential in time --

Q. Okay.

A. -- so much more time being spent in the office compared to time spent in the nursing home, that the numbers would probably be greater --

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Q. Okay.

A. -- seen as an outpatient.

Q. Okay. Fair enough.

Just to follow up on one point that we discussed earlier. Setting aside your reading and self-study of epidemiological literature and, of course, the statistics course that you took in medical school, have you had any other formal education in epidemiology or statistics?

A. By "formal" I assume that you are using that word to --

Q. I mean --

A. -- mean have I taken any other specific course work in epidemiology?

Q. Right.

A. No.

Q. Okay.

A. Well, that's not probably really quite accurate. In preparation for taking the board examination for the specialization in geriatric medicine, I took several very intensive courses of study.

Q. That was in 1987?

A. Well, and prior to, in the -- in the year or so prior to in preparation for taking the

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examination. And I am -- I'm sure that there were references to the epidemiological method during that period of time.

Q. Do you remember any specific courses you had to take on epidemiology or statistics?

A. No, I don't. I don't remember any specific, the names of them, or -- but I'm sure that that was a part of that. It was a fairly intensive course of study and I'm sure that that was a part of that, to some extent.

Q. Since you raised the point, what did you have to do -- what were the requirements to be board certified in geriatrics?

A. You had to pass an examination.

Q. Did you have to take the courses?

A. You did not.

Q. What were the courses that you took?

A. Well, they were courses relative to geriatric medicine.

Q. Who taught them?

A. They were at major universities. And I remember that I took three such courses. I don't recall exactly where they were, but they were -- each of them were several days. I think one of them was a week. I believe one of them was in Boston.

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Q. There were three. One was a week. Does that mean you had eight hours of class a day for a week?

A. Some of them were longer than that. We would meet for -- in the evening as well.

Q. Was the long -- you said the longest one was a week?

A. I believe that's right.

Q. How long were the other two?

A. I don't recall. My recollection is that most of them were four or five days and one I think extended for like six or seven days. And then I did a lot of self-study during that period of time.

Q. You don't remember where you took those classes? You said in Boston. Where in Boston?

A. I believe the course was taught at the Copley Plaza and it was sponsored by several of the Boston area hospitals. Another one was somewhere on the East Coast and I don't remember exactly where it was. And the third one I just draw a blank. I don't remember where it was.

Q. Is there some kind of national organization for geriatric medicine?

A. Well, there's a society for almost everything, so I'm sure there is -- and I'm sure

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there is. I don't know the name of it.

Q. So, you're not a member?

A. And I'm not a member.

Q. You're not a member.

What professional organizations are you a member of?

A. I'm a member of the AMA, the TMA, the American Society of Internal Medicine, which is now associated with the American College of Physicians.

Q. That's it?

A. At this time.

Q. The TMA is the Texas Medical Association?

A. Yes.

Q. How long have you been members of those organizations?

A. I joined the AMA sometime during my training --

Q. Uh-huh.

A. -- and the TMA in 1970.

Q. And the Association -- what was the internal medicine one called again?

A. The American Society of Internal Medicine --

Q. Oh, okay. Now part of the American College of Physicians?

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A. Now part of the American College of Physicians.

I don't really recall, but I'm -- I'm fairly sure it would have been fairly shortly after I began practicing in 1970.

Q. Uh-huh.

A. '70, '71, something like that.

Q. Were you ever a member of any others that you're no longer a member of?

A. Yes.

Q. Which ones?

A. I was a member of the American College of Cardiology, the American College of Angiology. It seems like there were one or two others, but that's all I can remember at this time. And I resigned from those when I retired.

THE VIDEOGRAPHER: Two minutes.

MS. WAGNER: Okay.

Q. (By Ms. Wagner) What's angiology?

A. It's the -- it has to do with -- it's vascular --

Q. Uh-huh.

A. -- disease and it has to do with the visualization of the vascular system and techniques and disorders relative to that.

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Q. I believe you asked me -- I asked you earlier if you were a cardiologist and you said no; isn't that right?

A. I am not board certified in cardiology.

Q. Okay. Do you have any level of expertise in cardiology?

A. Yes.

Q. Can you describe that for me?

A. Well, A, I took a year fellowship in cardiovascular disease; and, B, the practice of internal medicine involves a great deal of the practice of cardiovascular disease. And over time, I was particularly interested in cardiovascular disease and -- and our group as a group was interested in cardiovascular disease, so I think our group tended to attract a larger population of patients with cardiovascular diseases.

MS. WAGNER: All right. Why don't we switch the tape.

THE VIDEOGRAPHER: 11:21 a.m. This is the end of Tape 1. We're off the record.

(Discussion off the record.)

THE VIDEOGRAPHER: This is Tape Number

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2. It's 11:24 a.m. We're on the record.

Q. (By Ms. Wagner) Dr. Stiles, you said you did a one-year fellowship in cardiovascular disease; is that right?

A. That's correct.

Q. Was that your whole fellowship? I mean, did you do any other fellowships or was that it?

A. I'm not sure I understand the question. I -- I did a year's fellowship in cardiovascular disease. I didn't have a subsequent fellowship.

Q. Okay. Okay. That's what I was wondering.

You said that your practice group was interested in cardiovascular disease and consequently attracted a larger population of cardiovascular patients; is that right?

A. Yes.

Q. What percentage of your patients were seeing you for cardiovascular disease -- diseases?

A. Well, I wouldn't have any data for that, but as I'm just thinking about it, I would think probably more than half.

Q. And what was the -- what was the age stratification of those patients?

A. "Those" referring to patients with

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cardiovascular disease?

Q. The cardiovascular disease patients, uh-huh.

A. They would span from thirties up, age 30 up.

Q. Were any of those patients smokers?

A. Yes.

Q. Were their cardiovascular diseases related to their smoking in any way, in your opinion?

MR. COX: You're talking about the individual --

MS. WAGNER: Uh-huh.

MR. COX: -- patients?

MS. WAGNER: Uh-huh.

A. I don't think it's possible in any one individual to know -- since cardiovascular disease is obviously a multi-factoral disease, I don't think in any one individual it's possible to know in such an individual exactly why that individual has reached his current state.

Q. (By Ms. Wagner) Of -- of the cardiovascular disease patients, what percentage of them were smokers?

A. I would have no idea.

Q. What cardiovascular diseases are

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associated with smoking?

A. Primarily coronary artery disease, peripheral vascular disease, cerebrovascular disease and aortic vascular disease.

Q. Is cerebrovascular disease the same thing as stroke?

A. As a general term, yes.

Q. Do you believe that -- in your medical opinion, do you believe that smoking can lead to coronary artery disease, peripheral vascular disease, cerebrovascular disease or aortic -- is it aortic disease or aortic vascular disease?

A. I don't think you can use the word "lead to." What one can say is that smoking is a risk factor for the development of those diseases that you just mentioned, coronary artery disease, cerebrovascular disease, peripheral vascular disease and aortic disease.

Q. Is smoking a contributing cause to those diseases?

A. I don't believe it's possible to make that statement. It's, as I have just said, a risk factor.

Q. If the general population as a whole were to quit smoking, would the incidence of those

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diseases go down, in your opinion?

A. As a population --

MR. COX: Let me ask a point of clarification. You're talking about smoking or smokers?

MS. WAGNER: Smoking.

A. So, now I'm confused. Could you restate the question?

MS. WAGNER: I think that's what I said. Could you read back the question?

(The following was read by the Reporter: "Question: If the general population as a whole were to quit smoking, would the incidence of those diseases go down, in your opinion?")

A. If you have a -- if you look at it from the population standpoint and you reduce a risk factor that is associated in that population with certain diseases, the group as a whole will be at less risk.

Q. (By Ms. Wagner) So, is the answer to my question yes?

I'm not really sure that you answered my

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question. Do you want me to re -- reask it?

A. Well, I thought that was an answer.

Q. Well, it sounded to me like you were answering maybe a different -- a broader question.

Would the incidence if -- if the population, the general population quit smoking today, would you expect in the future the incidence of cardio -- the four cardiovascular diseases you named to go down in the population? And your answer was what?

A. Looking at the population --

Q. Uh-huh.

MR. COX: Let me first object to the question in that it -- the hypothetical does not assume or does not provide enough information to give a proper answer.

But you can attempt to answer it.

A. Well, I'd like to object to the hypothetical on the basis that, of course, no one's ever done that, so we don't really know what would happen.

Q. (By Ms. Wagner) Right. I'm just -- but I can ask you a hypothetical and if you can answer it, I'd like you to.

A. Well, I think it would be very difficult

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to answer the question because smokers as a group of people also engage in many other health behaviors which are not healthy. So, if you just took the smokers and had them stop smoking, I don't know that we know what the end result would be, because they are still -- they still have the other characteristics of smokers which are not healthy.

Q. To what unhealthy characteristics are you referring?

A. Well, they tend as a group not to go see the doctor and they tend as a group to seem to have less interest in their health.

Q. On what do you base that?

A. They tend to have riskier behaviors, riskier sexual behaviors. They tend to be less inclined to follow generally considered healthy diets. They consume a diet that's higher in fat and lower in fiber.

They tend to be in a lower socioeconomic group. They tend to consume more alcohol.

And I'm -- and I'm sure there are other characteristics, but that's all I can think of at this moment. Given more time, I might think of others.

Q. And what's your -- what's the basis for

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your knowledge about -- about that?

A. That's -- that's common knowledge.

Q. So, there's no study or article that you can cite specifically that supports --

A. I have read articles that relate to that issue, yes.

Q. Do you intend to rely upon those articles in your testimony in this case?

A. They're -- I don't know that I would use the word "rely," but they are useful and helpful, informative.

Q. Are those articles on your -- on your disclosure?

A. I don't believe so. Not that I recall.

Q. And you said you can't cite any specifically for me?

A. I remember a specific article. I can't at this moment tell you the journal and so forth.

Q. Okay. And you don't plan to, as you said, rely specifically on any particular article for that proposition?

A. No.

Q. Okay. When you say that smokers engage in riskier behaviors, what do you mean?

A. They tend to have, for example,

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occupations that are more -- occupations and/or hobbies, other uses of their time other than employment that are, in general, riskier.

Q. Riskier in what way?

A. In terms of threat to health.

Q. Physical health?

A. Physical health.

That reminds me. They also as a group tend to have more problems with depression and tend to have more problems with anxiety, speaking of mental health.

Q. Are you familiar with the term "synergy"?

A. Yes.

Q. What does that mean?

A. It means that two factors may have a collective association of risk, for example.

Q. What do you mean by "collective association of risk"? I don't understand what you mean by that.

A. Well, I assume that you're thinking about synergistic effects of risk factors, for example.

Q. Right. But what does that mean for risk factors to have a synergistic effect?

A. It means that in a population, in a statistical analysis of a population, if a population

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is found to have two factors under study that seem to be associated in a positive direction with a condition, disease, that it appears that those factors are leading -- not leading -- associated in the same direction with the same condition under observation.

Q. Is that all?

A. Do you have a question?

Q. Well, I wasn't sure that -- so, you're saying that for risk factors to have a synergistic effect, they just have to point in the same direction with respect to a disease end point? Is that what it means?

A. Said another way, that if -- again, the example I was using, if you have a population and you've studied them and you are looking at two conditions or life styles and relating that to a disease, those individuals who have two risk factors as opposed to those who have one risk factor will be at greater risk than those who just had the one risk factor or who have no risk factors.

Q. Would they have more than the amount of risk from adding the two risk factors, the risk from the two risk factors?

A. Yes.

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Q. So, in other words, a synergistic effect would mean that two plus two equals five, for example; that it's -- that the sum -- that the whole is greater than some of the parts, isn't that -- is that your understanding of synergistic or synergy?

A. I wouldn't want to put forth that synergism means that two and two equals five.

Q. Right. Well, we don't have to put real numbers, then.

A. Right. But the -- if risk factors are present, they may have a -- a risk factor by definition does not necessarily mean that it will be synergistic. You can have two risk factors who are not synergistic. If you have risk factors that are synergistic, by definition they will be more than additive.

Q. Okay. What are the risk factors for coronary artery disease?

A. Well, I will try to name several, as in a long list of things. I'll preface my remarks by saying I probably will inadvertently leave some of them out.

Q. Okay.

A. But with that preface, risk factors for coronary artery disease would include, at least, high

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blood pressure; abnormalities in the levels of certain lipids, such as cholesterol and other components of the cholesterol; smoking; family history; age; sex --

Q. You mean gender?

A. Gender.

The presence or absence of certain chromosomal abnormalities; diabetes; obesity; a prior history of having had a myocardial infarction; a sedentary life style.

And I'm sure there are others, but that's all I can think of right at this moment.

Q. Are those essentially the same risk factors for the other cardiovascular diseases that you named? Peripheral, cerebrovascular and aortic?

A. Yes.

Q. Are any of the risk factors stronger than any of the other risk factors? In other words, are they more predictive of the disease end point?

A. You're talking about in a population?

Q. Uh-huh.

A. Probably -- the strongest risk factors probably include hypertension, cholesterol abnormalities and smoking.

Q. In a population with high blood pressure

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and high cholesterol, does smoking have, if you know, a synergistic effect?

A. I believe I have seen studies where smoking was synergistic with hypertension and cholesterol abnormalities.

Q. Do you know the magnitude of the synergistic effect?

A. No, I don't.

Q. So, does that mean if -- in a particular population with high blood pressure and high cholesterol and who were -- who also smoked, taking that population, if they all quit smoking, would you expect their incidence of cardiovascular disease to drop?

A. Well, isn't that the same question that we discussed earlier, that if you just had the smokers and all you do to them is have them stop smoking, we don't know what would happen because they're still smokers in all the other aspects that we've just discussed.

Q. Well, I'm just taking two of the risk factors now, high blood pressure and high cholesterol. Say you have a population in those other two risk factors for -- that you've identified for cardio -- for developing cardiovascular disease

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and they also are smokers. If you take smoking out of the equation, do you expect their incidence to go down?

A. I thought I answered that question, but I'll say it again. I don't think we know the answer to that question because you haven't substituted nonsmokers for smokers. All you've done in this hypothetical is you have asked the smokers to stop smoking and that's different. They're still smokers. You've just asked them to not continue to smoke.

Q. Right.

A. So, they still have a number of other characteristics about them --

Q. Well, I've only -- in my hypothetical, they only have two. With respect to cardiovascular disease. I'm only talking about with respect to their risk for developing cardiovascular disease and I'm -- and the two risk factors that they have other than smoking are high blood pressure and high cholesterol.

A. And I'm saying that that's not a possible hypothetical, that smokers are smokers and inherent in that they have characteristics which are not healthy. So, you -- there simply is no such

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population as you describe where, in effect, you're saying what if we substitute nonsmokers? I'm saying, well, that's a different question.

Q. No, I'm not saying that, though. I'm taking away the behavior.

A. Well, and I'm saying you can't do that.

Q. So, are you saying that smoking cessation has no effect on the incidence of cardiovascular disease?

A. Well, that's a different question. I'm saying that we don't know what that impact would be in a population because the smokers are still smokers. They have this behavior. So, if you take a group -- well, I don't know how else to answer the question.

Q. What effect does smoking cessation have in a population at risk for cardiovascular disease?

A. I'm trying to think if I know of a study. I'm not sure that I can quote a study right now that answers that question.

Q. Without quoting a study, do you have any idea about what would happen to the incidence?

A. Well, I think it would be -- I think it would be difficult to know the answer to that because, as we've discussed, not only are smokers

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still smokers, but cardiovascular disease, for example, is such a multi-factoral entity and one manipulation might or might not have an effect one way or another. So, I'm having -- I'm just not sure.

Q. Didn't you say earlier that smoking has a synergistic effect in the presence of other risk factors for cardiovascular disease?

A. Yes.

Q. So, why isn't it true, Doctor, that if you take that out of the equation, that the risk would drop and the incidence rate would go down in a population?

A. Because you still have -- what we've been talking about, you still have the smokers in population. They're just -- in your hypothetical you just asked them to quit smoking.

Q. So, are you saying that the behavior of smoking itself has no effect, that the only thing that increases incidence of disease in a smoking population is the fact that we call them smokers and they have these what you listed as other -- only because they have other behaviors that are unique to them? The behavior of smoking itself has no effect, in your opinion?

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MR. COX: Let me object to the form of the question. Compound, convoluted and unintelligible.

If you have any clue as to what she's asking you, you can try to answer, Doctor.

THE WITNESS: I don't.

MS. WAGNER: Can you read the very last part of my question back?

(The following was read by the Reporter: "Question: The behavior of smoking itself has no effect, in your opinion?")

A. The behavior of smoking has no opinion --

Q. (By Ms. Wagner) Has no effect.

A. Has no effect on what?

Q. On the incidence of cardiovascular disease.

A. Well, we know statistically that smoking is a risk factor.

Q. What does that mean about the incidence, about its effect on the incidence of developing the disease? What does that mean?

A. It means that smokers have a greater risk, a greater incidence than nonsmokers --

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Q. Okay.
A. -- for certain diseases.
Q. Okay. So, smoking increases the incidence of cardiovascular disease; is that true?
A. There is a greater incidence of cardiovascular disease in people who smoke.
Q. And is that because they're -- they're inhaling cigarettes?
A. Well, as I've said --
Q. In part? Is that in part because they're inhaling cigarettes?
A. I don't think we know what part the fact that they are smoking plays. We know -- because they have many other characteristics which are detrimental to their health. So, what we know is that smokers, people who smoke, have a greater risk factor -- that is a risk factor for their development of, for example, cardiovascular disease.
Q. What is a risk factor?
A. The fact that they are smokers.
Q. What about the fact that they are smoking? Is that a risk factor?
A. Smoking is a part of the characteristics of smokers, but it's not the only part, it is a part.

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Q. Right. Is it a -- is it a significant part?

MR. COX: Objection. Vague as to what "significant" means.

A. I don't know what "significant" means in this case because it is only a factor in what makes up a smoker.

Q. (By Ms. Wagner) Does the -- does the act of smoking have any impact on the health of a smoker?

A. Well, we know that smoking a cigarette may cause certain acute changes in certain measured parameters which dissipate very quickly. So, beyond that, I'm not sure we know as a biological mechanism what the act of smoking does towards cardiovascular disease on a long-term basis.

Q. What are the acute changes that happen?

A. Well, there may be an increase in coronary artery resistance and a decrease in coronary artery blood flow. There may be a slight rise in blood pressure. And there probably are others -- may be others, but that's all I recall specifically right now.

Q. And what are the chronic effects of smoking?

A. Regarding cardiovascular disease you're

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talking -- asking?

Q. Right. Okay. We'll say the chronic cardiovascular effects of smoking.

A. If you look at a population, again not an individual, but if you look at a population, there may be a slight tendency to have the blood pressure in the group of people who smoke be slightly lower than in those who don't smoke.

Q. Is that the only chronic effect you can think of?

A. That's the only one I can think of right off.

Q. Setting aside the biological mechanisms and getting back to the effect in populations --

A. Would this be a good time to take another break?

Q. Sure.

THE VIDEOGRAPHER: 11:59 a.m. We're off the record.

(Discussion off the record.)

(Lunch recess taken.)

THE VIDEOGRAPHER: 1:10 p.m. We're on

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the record.

Q. (By Ms. Wagner) Doctor, before the lunch break, we talked a little bit about the biological mechanisms of the effects that smoking has on the cardiovascular system biologically and you mentioned that one of the chronic effects of smoking that you -- to your recollection was that it lowered blood pressure in a population. Do you know of any other chronic effects, cardiovascular effects?

A. Not that I can think of right now.

Q. There could be some, but you're just not aware of them?

A. There could be some of which I'm not aware and there could be some which I just don't recall.

Q. Okay. I think you told me earlier that you couldn't think of any exceptions and that you pretty much advised all of your smoking patients to quit smoking; is that -- is that true?

A. Yes.

Q. And you might have told me this, but I don't honestly remember. Why is it that you advise your patients not to smoke?

A. Because -- excuse me. Because smoking has been identified as a risk factor in populations

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as being -- I may have misspoke myself. Let me start again.

Because smoking has been identified as a risk factor in populations regarding certain disorders which we've discussed and, therefore, it seems prudent to encourage people to discontinue risk factors over which they have some control.

Q. So, does your -- is it fair to say that your knowledge about epidemiological findings influences the advice that you give to patients in your clinical practice?

A. Well, I would say that it has some influence on how I might advise my population of patients, yes.

Q. Okay. And you said that you've treated -- that the majority of your patients -- I think you said the majority of your patients came to you for cardiovascular diseases; is that true?

A. No.

Q. Oh, it's not?

A. That's not. I don't believe I said that. If I did say that, I misspoke myself.

I believe I said something along the lines that it became heavily weighted towards cardiovascular disease because of my interest and the

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group's interest, and it's possible that as many as 50 percent. So, I guess you used the word "majority" --

Q. Okay.

A. -- yes, then I would agree with that.

Q. Okay. And some of those patients were smokers?

A. Yes.

Q. Is it your belief that smoking cessation in any one of those cardiovascular patients who smoked would have reduced their -- would have -- would it have improved their chances of surviving their cardiovascular disease?

A. I want to make sure that I understand the question. You've asked in any one patient, if, for whatever reason, that patient discontinued smoking, would that have an effect on their cardiovascular disease? Is that the question?

Q. Yes.

A. I don't think it's possible to know the answer to that question.

Q. You can't think of any patient with -- that you've treated where that would have been the case?

A. I don't think in any one patient it's

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possible to know what effect smoking cessation will have on their cardiovascular disease because cardiovascular disease is a multi-facetted disorder.

Q. Is it possible to know with respect to a population what effect smoking cessation will have on their cardiovascular disease?

A. Well, as we discussed earlier, asking smokers to stop smoking doesn't make them nonsmokers. They continue to be smokers and they have many factors about them which continue to have adverse effects on their overall risk profile as a group.

Q. So, would you disagree, then, Dr. Stiles, that a smoker's risk of, let's say, coronary heart disease returns to that of a never smoker within a certain number of years after smoking cessation?

A. I don't think in a smoker you know the answer to that question.

Q. Okay. And you don't know the answer to that question, do you?

A. No, and I don't -- in a smoker, no, I don't think that that -- I don't think the answer to that question is known.

Q. Okay. Okay. How many depositions have you given before?

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A. Lifetime?
Q. Yes.
A. Again, not a statistic that I have kept track of. I would say in the order of magnitude of a dozen.
Q. And do you ever --
A. Give or take a few. I --
Q. Okay.
A. -- but that's -- it's in that ballpark.
Q. Okay. What did those cases involved -- involve in which you gave deposition testimony?
A. Well, starting with more recent times, which I have a better recall about, I gave a deposition in a case where the allegations, the plaintiff allegations were that the care that an elderly lady received at the hands of two physicians in a hospital was below the standard of care.
Q. So, that was a medical malpractice case?
A. Yes.
Q. And who were you testifying for in that case?
A. The plaintiff.
Q. Okay. When was that?
A. That would have been in the past two or three or four years, something like that. It is one

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of the cases listed and if --

Q. Okay. I was just trying to -- I was looking at your --

A. If there's a date there --

Q. -- 6(D) disclosure which is part of Exhibit --

MR. COX: 2.

Q. (By Ms. Wagner) 2.

MS. WAGNER: Thanks.

A. Okay. That would have been --

Q. (By Ms. Wagner) Which one was that?

A. That second one. That would have been in 1994, then.

Q. The Jessie Crow --

A. Yes, uh-huh.

Q. -- versus Methodist Hospital?

A. Uh-huh.

Q. What was the Bonnie Wils versus Beverly Enterprises?

A. Yes. That was a -- involving nursing home patient who had been found entangled in a restraint and expired.

Q. She died?

A. She died.

Q. And, so, was that also a medical

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malpractice case?

A. Yes.

Q. Or -- okay. And who were you -- for whom were you testifying in that case?

A. The defense.

Q. What about Garcia v Garcia?

A. That involved a motor vehicle accident and there were questions regarding consumption of alcohol and I testified for the defense.

Q. What was the subject of your testimony in that?

A. I don't remember the particulars of the case really much beyond what I've already said. I remember there was some question about who had consumed what in the way of alcohol and when and, as I recall, there was some issue about whether the -- one of the drivers -- one of the passengers should have not gotten in the car at the time, whether he should have known about the other's ability to drive, but it -- that's about all I remember about that.

Q. Do you remember what your expert opinion was in that case?

A. Not in any detail. I remember that there were --

Q. You were an expert witness; right?

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A. I was.
Q. Okay.
A. I just don't recall. It had to do with what could be known about the state of the driver and the passenger in terms of knowing what the other had had to drink and how well they were able to make decisions about being in a vehicle, but beyond that I -- I just don't remember the details.
Q. What was the basis for -- for your being called as an expert in that case?
A. I -- I don't know. I was asked and at the time there were enough additional details that made it clear to me that I could offer an opinion relative to the issues that were on the table at the time, but I -- I just don't remember what those issues were.
Q. So, you don't know whether you were asked to discuss the blood alcohol level?
A. That was a part of it.
Q. What's your experience with that?
A. Very limited.
Q. Do you know why you were called?
A. I -- I don't.
Q. Were you paid for your time --
A. I was.

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Q. -- in that case?
How much?
A. I don't recall.
Q. How about in the Crow and the Wils cases, were you compensated for your time in those cases?
A. I was compensated for my time.
Q. Do you remember how much?
A. I do not.
Q. Do you remember what your hourly rate was in 1994?
A. I don't.
Q. What's your hourly rate now for --
A. $500 an hour.
Q. 500?
How much have you billed in the State of Oklahoma case so far?
A. I think around 40 hours.
Q. And what have you -- what have you done in those 40 hours, what type of work?
A. I've reviewed literature. I have had telephone calls. I have met with attorneys. And I've thought about it.
Q. And you haven't produced any written reports with respect to your testimony in this case, have you?

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A. I have not.

Q. You were also deposed in the State of Texas versus the American Tobacco Company tobacco litigation; is that right?

A. Yes.

Q. Was the opinion that you were prepared to offer in the State of Texas case essentially the same as the one you're offering in this case?

A. Well, that's a very broad question. I was -- they asked a lot of questions at the deposition. My fundamental opinion, however, I was -- would say is the -- is the same then as it is now.

Q. And can you think of any answers to questions you gave in that previous deposition that you would change now given the chance?

A. Well, I have thought a bit -- thought more about the broad topic of causation.

Q. Disease causation?

A. Disease causation.

Q. Diseases caused by smoking?

A. Well, just the -- the --

MR. COX: Let me object to the form of the question. It assumes that disease is caused by smoking.

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But you may answer.

A. So, what was the question?

Q. (By Ms. Wagner) You said you've thought about the broad topic of causation and then I said disease causation and you said yes and I said disease --

MR. COX: I don't think he said yes.

MS. WAGNER: He said disease causation. Sorry.

Q. (By Ms. Wagner) You repeated what I said. And then I asked diseases caused by smoking?

A. Well, I think I've testified earlier that I am not prepared to agree that we know through any kind of biological mechanism that smoking causes any disease.

Q. Have any plausible biological mechanisms been suggested for any smoking-related disease that you're aware of?

A. Well, I'm sure -- I'm sure there are hypotheses, but to my understanding, there is no agreed upon hypothesis by which smoking has been shown in a scientific biological mechanism way to cause cancer.

Q. Do you know what any of those hypotheses are?

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A. I -- I'm not prepared to discuss that.
Q. So, you can't -- as you sit here today, you can't name or describe any of the hypotheses for me?
A. Not in any kind of detail that would be meaningful, no.
Q. Okay. And what was your -- you said that you've -- since the Texas deposition you've had occasion to think about causation. Did you testify specifically to the issue of whether smoking causes disease in the Texas deposition?
A. There were a number of questions and I don't remember exactly how they were phrased, but there were questions that were posed to me inquiring about smoking as, I'll just put it in quotes, causing, quotes around "causing," various diseases and I believe I said at that time something to the effect that I wasn't really prepared to discuss causing -- causing in that context as an expert.
Q. So, has your opinion about anything in the -- that you testified to in the Texas deposition changed from that time to now?
A. My opinion regarding what?
Q. Regarding causation or anything else you can think of.

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A. Having thought more about that issue of causation and what the term means and -- I -- I wouldn't say that I -- I don't have a Ph.D. in causation, but I think I have some expertise in analysis of data relative to whether something -- certain things are known, and again I put that word in quotes, "known" in terms of causation or not.

MS. WAGNER: Could you read back the last part of that response?

(The following was read by the Reporter: "Answer: Having thought more about that issue of causation and what the term means and -- I -- I wouldn't say that I -- I don't have a Ph.D. in causation, but I think I have some expertise in analysis of data relative to whether something -- certain things are known, and again I put that word in quotes, 'known' in terms of causation or not.")

(Counsel reviewing the Reporter's realtime screen.)

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Q. (By Ms. Wagner) What is the basis of your expertise regarding whether certain things are known in terms of causation?

A. Okay. You kind of hesitated along the way and I lost the -- the question. Could you -- could you restate the question?

Q. I'm trying to use what you just said to formulate mine and --

MS. WAGNER: Can you read it back?

(The following was read by the Reporter: "Answer: Having thought more about that issue of causation and what the term means and -- I -- I wouldn't say that I -- I don't have a Ph.D. in causation, but I think I have some expertise in analysis of data relative to whether something -- certain things are known, and again I put that word in quotes, 'known' in terms of causation or not.")

MS. WAGNER: And then read my question.

(The following was read by the Reporter:

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"Question: What is the basis of your expertise regarding whether certain things are known in terms of causation?")

Q. (By Ms. Wagner) What do you mean by that? Let me ask you that first. When you say you have a certain amount -- you don't have a Ph.D. in causation. I assume no one has a Ph.D. in causation?

A. Well --

Q. I've never heard of such a thing, have you, Dr. Stiles?

A. I mean, I've not heard of a Ph.D. specifically in causation --

Q. Okay.

A. -- but I would think that maybe there are people who deal more with that on a day-to-day basis than perhaps I do.

Q. Okay. What kind of people?

A. Statisticians, for example.

Q. Okay. But you did say that you had a certain amount of expertise in whether something is known, quote/unquote, in terms of causation. Can you explain what you mean by that?

A. Yes. As I have thought about what is not

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known about the steps between the fact that people smoke and people develop various diseases in populations, it's clear to me that we really don't know in any kind of a biological mechanism that there is there is a cause and effect relationship. There may be some statistical associations. Smoking may have an association with certain end results. But in terms of a knowledge or an understanding of any cause and effect relationship, that's not known.

Q. So, short of having a demonstrated biological mechanism for the cause and effect relationship between smoking and disease -- first of all, if such existed, if -- if a biological mechanism did exist that could be proved, would you then accept that smoking caused disease?

MR. COX: Let me object to the form of the question in that there was a preface, a second question, and I'm not sure which question is being asked.

MS. WAGNER: The last question's being asked.

A. So, what is the question?

MS. WAGNER: Can you repeat the question -- can you reread the question, please?

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(The following was read by the Reporter: "Question: If a biological mechanism did exist that could be proved, would you then accept that smoking caused disease?")

A. I am not prepared to even attempt to answer that question because the hypothesis is clearly unknown. We clearly don't know that there is a biological mechanism by which cancer, quote, causes, quote, an adverse effect on health, the various diseases that we've discussed.

Q. (By Ms. Wagner) But my question to you is, Dr. Stiles, if any of the biological mechanism hypotheses that are currently out there were proved, would you then accept the idea that smoking caused disease?

A. Well, I think what I would have to do is I would have to look at the proposed hypothetical, proposed theory, and I would have to make a judgment as to whether I was satisfied that that had been shown or not.

Q. And if you were satisfied?

A. If I could be shown the biological mechanisms by which smoking led to a disease to my

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satisfaction and in my judgment that that seemed to be accurate and true, then in that situation, I would be willing to say that it has now been shown to my satisfaction that smoking causes -- or at least is a participant in the cause of certain disease.

As in all -- as we've discussed before, all these diseases that we've discussed are multi-factoral. So, even if that hypothetical that we've just discussed were existent, one could not say is the cause because, after all, there are people who have these diseases that don't smoke. So, it can't possibly be the cause.

Q. But we know that now, don't we, Dr. Stiles?

A. Know what?

Q. That there are all kinds of people who have the diseases who don't smoke.

A. We know that, yes.

Q. Does that mean that smoking is not a cause of those diseases in any person?

A. Well, is -- is your question in people who don't smoke -- I'm not sure I understand. Would you restate the question rather than me try to restate it?

MS. WAGNER: Could you read it back,

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rather than have me try to restate it another way?

(The following was read by the Reporter:
"Question: Does that mean that smoking
is not a cause of those diseases in any
person?")

Q. (By Ms. Wagner) And again, when I say "those diseases," do you know what diseases I'm talking about?

A. I -- yes, I believe so.

Q. Okay.

A. And, I'm sorry, that just threw me off.

THE WITNESS: If you could read the question now.

Because I understand your premise.

So, if you could read the question again.

I was ready to answer it until you threw that in.

MS. WAGNER: I'm sorry.

(The following was read by the Reporter:
"Question: Does that mean that smoking
is not a cause of those diseases in any

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person?")

A. And as I have discussed, I'm not prepared to agree that smoking has been shown to cause any disease.

Q. (By Ms. Wagner) What is the basis for that assertion?

A. Because there are no scientific biological mechanisms that have been demonstrated to show those steps that smoking causes the diseases that we have been discussing.

Q. What has the epidemiology demonstrated with respect to the relationship between smoking and cardiovascular diseases?

A. Well, epidemiology studies have been done, statistics have been analyzed, and as we have discussed, there has been shown a risk factor relationship between smoking and cardiovascular disease -- is that the one that you --

Q. Yeah, I picked cardiovascular disease.

A. Cardiovascular disease.

So, there has been shown a statistical relationship between people who smoke and the development of cardiovascular disease in smokers, but you cannot prove causation from statistics.

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Causation requires that you go beyond statistics and make a judgment.

Q. Right. And I was -- I was just asking about the epidemiology, actually, in that last question.

Are smokers as a population -- strike that. I'll come back to that.

What caused you to ponder the issue of causation after your deposition in the State of Texas case?

A. I -- I don't know the answer to that. Just thought more about it.

Q. Did any of the lawyers talk to you about your testimony about causation in that deposition?

A. We've talked about causation, but I don't know that that was what initiated my thinking about that.

Q. What did -- what did the lawyers tell you about the issue of causation?

A. Well, we have -- we've just discussed it sort of in general as a -- as a concept about cause and effect and what, in a legal sense, which is not the world that I live in, the implications of that work are.

Q. Have you -- other than the conversations

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you had with the lawyers and your independent thought on the subject, have you tried to read more about the disease causation issue since the Texas deposition?

A. I -- I have read the 1964 Surgeon General report.

Q. Anything else?

A. I read a report from the Surgeon General's office of 1982, I believe it was. I don't recall the title of that, but it was an additional report from the Surgeon General's office.

Q. You said 1982; is that right?

A. Yes.

Q. Okay. So, do you rely on those two reports in -- for your testimony about disease causation?

A. I wouldn't use the word "rely." They were useful, helpful and informative.

Q. With respect to that particular issue?

A. Well, yes, with respect to that issue.

Q. What was the Hoffman v Brazos Valley Geriatric Center case about?

A. This was a case about a nursing home and a resident had fallen and broken a hip.

Q. And who were you testifying for in that case?

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A. The defense.
Q. What was the nature of your testimony?
A. That the care provided by the nursing home was within the usual and customary.
Q. So, that was also a medical malpractice case?
A. Yes.
Q. Before your testimony in the -- or before you were retained as --
A. May I interrupt just --
Q. Sure.
A. I don't know whether it's important or not, but you had earlier asked me to tell you about all the depositions I had done in my life.
Q. Oh, yeah, and these were only a couple of them. These are only since 1982.
A. Right.
Q. You want to tell me about the others?
A. I just need to say that there were others.
Q. Okay. Do you know what they involved? Do you remember?
A. Let me think a minute.
There was a case that involved a nursing home patient who was a patient of mine who had gone

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to the emergency room. I was not in that case an expert witness, I was a fact witness, I --

Q. Were you a party in that case?

A. I wasn't a party. I'm not sure of the legal terms. I was asked to testify --

Q. Were you a plaintiff or a defendant?

A. I was not a plaintiff. I wasn't a defendant. I was asked to testify because this patient was my patient, but I was not involved in the suit. So, I don't --

Q. Who was the defendant in the suit?

A. The emergency room physician.

Q. And your patient was the plaintiff?

A. The patient's family was the plaintiff.

Q. Okay. And what was -- what --

A. Well, the gist of it was that I was asked to testify about my patient and -- this is a decade or more ago -- I think sort of more about his general condition and what he was like more than what was related to what went on in the emergency room.

Q. What was the issue in that case? He died?

A. He died. He had an infection in his throat and the allegation was that he died because his throat became swollen and he was unable to

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breathe. That was the allegation, as I recall.

Q. And you testified about his general condition while he had been a patient of yours?

A. Yes.

Q. Okay.

A. I -- I don't remember that I was even asked to make any judgment or comment or express an opinion about the care he received in the emergency room.

Q. Okay.

A. It was more of a background, as I -- as I recall.

Q. And that was about ten years ago?

A. At least. Maybe more. Probably more. Probably more than 15.

Q. Well, if it's not on this list since 1982, is it fair to say that it's probably more?

A. You do the math very well. Yes, it was probably in the --

Q. More like 20?

A. -- 1970s.

Q. Okay. What about -- what others?

A. There were others and when I said that, I thought I would probably recall more of the details of them, but I really don't. I just don't remember.

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Q. You don't recall the others?

A. But I wanted to be very clear that there have been other cases.

I was sued once.

Q. Oh, okay. What was that lawsuit about?

A. This was a -- it would have been in the seventies.

Q. Okay.

A. And I was -- it involved an orthopedic patient who had undergone surgery, a second and I think third and fourth times, on a -- on a hip. He'd had a hip replacement and he had --

Q. Was this a geriatric patient as well?

A. Yes.

Q. Okay. Go ahead.

A. And he developed an infection and there was the question of whether he had bleeding from the bowels. And I was asked to see the patient relative to the problem of -- and the question, the issue of bleeding from the bowels. That's how I became involved in the case.

And the orthopedist prescribed antibiotics for his infection and it was during the course of his treatment in the hospital he developed kidney failure and decreased hearing. And the

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allegation was that these were side effects of the antibiotics and I was sued relative to that issue and I -- I was unsuccessfully sued. They were not successful in showing that I had anything to do with --

Q. The prescription?

A. -- the prescribing of the antibiotics or the renal failure or the loss of hearing, so I was told.

Q. Okay. Overall would you say you've testified more on behalf of plaintiffs or defendants?

A. Defendants.

Q. When did you first become involved as an expert on behalf of the tobacco companies?

A. I received a phone call I believe in -- on or around April of 1997.

Q. Who called you?

A. An attorney named James Ebanks.

Q. What law firm is James -- Ebanks or Eubanks?

A. "E." Ebanks.

Q. What law firm is James Ebanks with?

A. I believe it's something like Giessel, Lyman & Baker, maybe it could be Barker. It's a firm here in town.

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Q. Here in Houston?
A. Yes.
Q. And what was the nature of the phone call? What did -- what did James Ebanks say when he called you?
A. I don't remember exactly the context, but it would be -- it would have been something along the lines of would I be interested in or available for -- I don't remember the terms -- exploring testimony as an expert, as a gerontologist, as someone with experience in nursing home care relative to the tobacco industry or -- I don't remember exactly how it was phrased, but that was -- it was a very short conversation, as I recall.
Q. Do you know did Mr. Ebanks tell you how he had heard about you?
A. Well, no. He -- he almost certainly wouldn't have made any reference to that because I had been asked to review at least one and it seems like maybe two malpractice cases for their firm in times gone by.
Q. Which cases were those?
A. Those were cases in which I gave no deposition. I was just asked to review --
Q. You were a consultant?

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A. I was retained as a consultant to review the records. And I believe there were two cases. I don't remember their details.

I -- I know -- I think one of them was a nursing home case and another one had to do about -- there was some issue about a physician and his prescription of anticoagulation medication.

So, that's how he knew me.

Q. Did he tell you what -- what your experience with nursing home patients had to do with the tobacco case?

A. I -- I don't -- I don't think so at that time. Is that -- my recollection is that it was a very brief conversation and I don't think there were a lot of details. It had to do with the fact that I was -- had expertise in the field of geriatric medicine and I don't -- I don't recall if the issue of nursing home came up at the time.

Q. Did you agree at that -- on that first phone call to serve as an expert for the tobacco companies?

A. No.

Q. When did you decide to go ahead and do that?

A. Well, we had a meeting of Mr. Ebanks and

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I think a couple of other attorneys --

Q. Do you remember their names?

A. Yeah. Her last name was Lewis.

Q. A woman?

A. A woman.

Q. Do you know the law firm she was with?

A. Shook, Hardy & Bacon.

Q. And besides Ms. Lewis, do you know who else was there?

A. I believe there was an attorney there -- there was another attorney there. I believe his name was Curtis and I --

Q. That was his first or his last name?

A. His last name. And I don't know what law firm he -- I don't know whether he was also from Shook, Hardy & Bacon or whether he was from another law firm. I just don't know.

Q. How --

A. And there may have been one other attorney there.

Q. Okay. And do you remember who that was?

A. I sure don't.

Q. And how long after the phone call was that meeting?

A. I will say within a week or two.

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Q. And did -- is it then that you agreed to serve as an expert at that meeting?

A. I'm not sure. I remember we discussed some of my opinions about why people go into a nursing home, my experience, and I -- I don't remember whether it was at that meeting or then there was another meeting within another two or three weeks.

Q. Who was at that meeting?

A. Well, Ms. Lewis and I believe Keith Borman from Shook, Hardy & Bacon.

Q. Keith Borden?

A. Borman.

Q. Borman. Anyone else?

A. I've really lost track of how many meetings there were. There were, let's say, three or four meetings.

Q. In connection with the Texas case?

A. Right. And at one of those meetings there was another attorney who I am pretty sure was not with Shook, Hardy & Bacon and her name was Lucy Eisenberg, I believe it was. I believe that's right, Eisenberg. And I can't -- I don't remember exactly where in there I agreed to be retained as a -- as an expert.

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Q. How many hours did you work in connection with the Texas tobacco case?

A. Somewhere around 100 hours maybe, maybe a little more. I don't remember exactly, but in that range.

Q. And did you charge a $500 per hourly rate as well in that case?

A. Yes.

Q. When did your work on the Texas case end? Do you remember?

A. In -- in July of '97.

Q. When were you first contacted with respect to the Oklahoma case?

A. I don't know. I don't remember. There -- it would have most likely been a phone call sometime after that and I don't -- I don't remember -- I don't remember for sure who even asked me that question.

Q. What lawyers have you met with in connection with your work in this case?

A. Keith Borman, John Holtman --

Q. Who?

A. Holtman.

Q. Holtman? Uh-huh. Who is he with?

A. Shook, Hardy & Bacon.

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Q. Okay.
A. And Mr. Cox. Cynthia Colcott.
Q. Who is she with?
A. I believe it's Jones, Day and two other names. Maybe it could be Day, Jones.
Q. Reavis & Pogue? I know the firm.
A. Okay.
Q. Okay. Jones, Day is sufficient.
A. All right.
Q. You mentioned earlier that you do consulting work and you've done consulting work for that law firm that James Ebanks was with, two medical malpractice cases. When did you first start doing consulting work in legal cases?
A. Probably in the late 1980s.
Q. And since that time, how much of your time has been devoted to consulting in legal cases?
A. Well, while I was still in practice, it would have been very infrequent.
Q. So, less -- what does that mean? Less than --
A. Maybe a couple times a year.
Q. Couple times a year.
A. There was a period of time for about a year, year and a half, ending in 1970, where I worked

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for --

Q. Ending in 1970? Is that what you said?

A. If that's what I said, I misspoke myself.

Q. Oh, okay.

A. I meant to say ending in 1997.

Q. Okay.

A. It was for a year or so there where I was employed by a law firm not as an expert, but just as a physician to assist them in numerous medical matters being defended by the law firm.

Q. What law firm was that?

A. McFall, Sherwood & Sheehy.

Q. Are they here in Houston?

A. Yes.

Q. And were you a full-time employee?

A. No.

Q. How -- how many hours a week did you work for them?

A. It was very variable. I would say average -- well, it's hard to average because there were many weeks where I didn't -- didn't work at all. I would say the most that I would work would be in the range of around 30 hours a week, with rare exceptions. There might have been weeks where I would work 40, but that would have been a very

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unusual situation. Most of the time it would have been 20, 25 hours.

Q. And --

A. Maybe 30.

Q. And did they -- maybe 30?

And did they typically -- did this law firm typically represent defendants in medical cases or plaintiffs or both?

A. Well, I can't knowledgeably answer that question because it was -- there were a number of attorneys and I had no knowledge of what most of them did. So, I can't really answer that question.

Q. How about the ones that you worked with? Who were they, first of all?

A. Who were the attorneys with which I primarily worked?

Q. Right.

A. William Sherwood.

Q. Uh-huh.

A. I'm just drawing a complete blank on the other two. There were two other attorneys that I worked with there. Maybe their names will come to me, but right now I don't remember either one of them.

What I was going -- to complete my answer

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about a former question, I know that there was at least one or two cases where one attorney was representing the plaintiff. So, I know that the firm did both kinds of work and I sort of got the impression that most of the work was done on the defense side, but I could be wrong about that because there was so much that went on that I didn't -- I had nothing to do with. I didn't even know all the attorneys that were there, let alone know what all they did.

Q. Right. Well, with respect now to the cases that you were doing consulting work on, do you know which side -- on behalf of which side you were testifying?

A. I didn't testify in any of these cases.

Q. I mean -- okay. Do you know which side the lawyers that you were working with and who asked you for your opinion were representing?

A. The majority of the cases with which I was in any way involved had to do with the defense side.

Q. Okay.

A. But one of the attorneys whose name I cannot recall at this moment, did both --

Q. Okay.

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A. -- because he -- I remember he asked me some questions about -- I believe there were at least -- there were two cases, I'm sure, that had to do with his representation of a plaintiff and they had to do with medical issues.

Q. So, were these essentially on medical malpractice cases that they were asking for your opinion about?

A. Well, yes. There was a case that involved numerous plaintiffs where I wasn't so much being asked opinions, but I was assisting in the collection of data, medical data relative to the numerous plaintiffs.

Q. Were you typically asked -- was that -- was that the nature of most of your consulting work, that you gathered data, or was it more often than not that you were being asked to render an opinion about a case?

A. Well, I don't want to mislead you in any way. The -- that about which I just spoke about the gathering of the data -- perhaps I -- the word "gather" was not well chosen -- I didn't have anything to do with going out and getting the information. The records were available at the firm, so I had nothing to do with gathering information.

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There was a large volume of data, then, that needed to be organized, would be a better way to say, and I participated in deciding what to gather and how to gather it in a retrievable kind of way.

Q. Okay. Did any of the consulting work that you've done involve nursing homes in any way?

A. Yes. A number of the cases that I have reviewed that have not come to the point of deposition have had to do with nursing home issues, yes.

Q. Can you tell me what those issues were?

A. Well, they involve either the home and the personnel at the home or the physician caring for the resident at the home or both. And the issues had to do with was the care rendered by the home and/or the physician, in my opinion, within the usual standard of care in the community.

Q. And you were, if I understand correctly, the party for whom -- or law firm for whom you were doing consulting work with regard to these nursing home issues was typically representing the nursing home, nursing home staff or physician?

A. I'm sorry. I completely lost you in there.

Q. Okay.

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A. Now, when you're speaking of --
Q. We're talking about your consulting work now.
A. -- you're talking about McFall in general or --
Q. I was actually talking about the consulting work in general that you've done for nursing homes.
A. Consulting in general.
Q. That you've done with respect to nursing home issues.
A. Okay.
Q. You defined those issues for me and my question to you is now: Were you usually doing consulting for the law firm that was representing the nursing home, the nursing home staff and/or the physician who rendered care in the nursing home?
A. Did you say either/or?
Q. Right.
A. To make sure I understand the question, I -- I would more often than not be asked to review cases as consultant to the defense --
Q. Right.
A. -- as opposed to the plaintiff. Does that -- is that your question?

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Q. I think so. Because usually the people who are the defendants are -- in these types of cases would be the nursing home itself, the nursing home staff or the physician who rendered care at the nursing home; is that right?

A. Yes.

Q. Do I have that right?

A. Yes.

Q. Okay. Had you ever had any consulting relationship with Shook, Hardy & Bacon before you worked with them on the tobacco litigation?

A. No.

Q. Okay. Any other law firm that represents the tobacco companies in either -- that did either in the Texas case or that does in the Oklahoma case?

A. Well, I have to answer not to my knowledge.

Q. Okay.

A. There could well have been law firms involved in that litigation and I would have no way of knowing that.

Q. Okay. You might have answered this question before, but forgive me. Have you ever provided any geriatric care to anyone in Oklahoma, at any nursing facility or hospital in Oklahoma?

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A. If I've understood your question, there are two questions. One, have I ever rendered care at a nursing home in Oklahoma? And the answer is no.

Q. At a hospital in Oklahoma?

A. No.

Q. To anyone in Oklahoma?

A. Well, that's the second part of the question, at least the way I understand the question. I would not have rendered any care to anyone under any circumstance at any place if they were in Oklahoma.

Q. Okay.

A. I might have rendered care to them in Texas and they moved to Oklahoma.

Q. All right. I understand the distinction.

Dr. Stiles, we've talked a lot about smoking-related diseases, not only cardiovascular diseases, but also --

A. It sounds to me like you're getting ready to --

Q. Do you need to take a break?

A. -- ask a new series of questions. Is this a good time to take a break?

Q. Yeah. Yeah, that's fine.

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THE VIDEOGRAPHER: 2:16 p.m. We're off the record.

(Recess taken.)

THE VIDEOGRAPHER: 2:25 p.m. We're on the record.

Q. (By Ms. Wagner) Okay. Before the break, Doctor, I was going back to what we had discussed earlier. We've listed a lot of diseases, both cardiovascular and other cancers, etcetera, etcetera, that are generally recognized by the medical community as being associated with smoking. Do you recall that?

A. Yes. I prefer to use the word "risk factors" association, just to be sure there's no mistake about the terminology, that smoking is a risk factor associated with the diseases that we've been discussing in general.

Q. Oh, okay. Rather than "associated"?

A. Well, I just -- I don't want there to be any mistake about what I'm saying.

Q. Okay. I'm sorry. If I could understand the distinction that you're making there, because I'm not sure I do.

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A. Well, sure. When I use the word "risk factor," in my mind it's very clear what that says, what that means. In my mind it's very clear what an association is. I'm not sure that everyone has as clear in their mind the implications of those words as I mean them to mean when I use them.

Q. Right. And --

A. So, if I use the word "risk factor" --

Q. Uh-huh.

A. -- as opposed to association, in my mind and in my terms of expressing what I'm meaning that's perhaps clearer, more unmistakable what I'm talking about than if I just used the word "association." Although I may have -- in our discussion I may have just --

Q. Uh-huh.

A. -- used the word "association" --

Q. Uh-huh.

A. -- but just so there's no mistake.

Q. What's the distinction? What is -- what is the risk factor as compared to an association?

A. In my mind, as we --

Q. Uh-huh, in your mind.

A. -- as I have been using the term and intend to use the term, the association is a

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statistical association as --

Q. Okay.

A. -- brought out from epidemiology studies and a statistical analysis of that data --

Q. Uh-huh.

A. -- leading to conclusions relative to risk factors. I don't want there to be any unclarity about how I'm using those terms. That's all.

Q. So, risk factors -- but would you agree that risk factors are identified through epidemiology? By finding a statistical association between the factor and the disease end point, you conclude that the factor is a risk factor for the disease end point?

A. Well, yes, that's sort of the --

Q. Is that right?

A. Well, I want -- I want to be sure. I'm going to say what I want to say --

Q. Okay.

A. -- and see if you're saying the same thing --

Q. Yeah. Okay.

A. -- that epidemiology studies have to do with studying certain conditions or behaviors and certain diseases and seeing if there seems to be any

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relationship --

Q. Okay.

A. -- association --

Q. Okay.

A. -- as a population study --

Q. Okay.

A. -- and analyze from a statistical standpoint. And when there seems to be a positive association, then that condition or life style or behavior is called a risk factor.

Q. Okay. So, we've talked at length today about various diseases for which smoking is generally recognized to be a risk factor? You do recall that discussion?

A. Yes.

Q. Okay. Does smoking lead to earlier onset of those diseases?

A. Smoking is a risk factor for those diseases.

Q. Does it lead to earlier onset of those diseases?

A. I -- I don't -- I don't think I've ever thought about onset. It's either a risk factor or it isn't and I'm not sure that the statistics address onset.

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Q. So, does that mean you don't know whether smoking leads to earlier onset of those diseases?

A. Again, I -- I don't -- I don't believe that -- onset would have to do with an individual. A population doesn't have an onset. An individual might have an onset, but a population won't have an onset.

So, since all we can do in -- with a population is to say whether there's a risk factor for -- for that population or not, we didn't address onset. Onset would have to do with an individual and since, as we've discussed at some length, to my satisfaction smoking has not been shown to have a causal relationship, but I don't believe you could discuss onset.

Q. Isn't it possible to aggregate data about individuals?

A. I don't know what you mean.

Q. Can't -- isn't it possible to look about -- to look at onset data of disease in a group of individuals and see what the pattern is in the -- in that group?

A. I'm -- I'm sorry. I just don't understand what you mean.

Q. You don't know what I mean when I say

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"aggregate data"?

A. I don't know what you mean in terms of what we're talking about here. I know what aggregates are, but I don't understand the question as -- in the word as you're using it in your question.

Q. What are aggregates, as you understand them to be?

A. I would say groups.

Q. Okay. Is it possible --

MS. WAGNER: Okay.

Q. (By Ms. Wagner) So, is it possible to group the data about the onset of disease in X number of individuals?

A. I'm trying to think of an example to satisfy myself to answer your question.

So, is the -- let me ask if this is the question you're asking. If you had a group of people and they all came down -- and out of that group of people a number of them came down with a certain disease X and some of them came down -- were diagnosed with this disease at various ages --

Q. Right.

A. Is that the kind of thing that you're asking?

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Q. Uh-huh.

A. All right. Now I understand that, what is the question relative to that aspect?

Q. Okay. Can you group --

A. The fact that you can take people with the same disease --

Q. Right.

A. -- and say this one got it at one age --

Q. Uh-huh.

A. -- and this one got it at another?

Q. Uh-huh.

A. Now, what is the question?

Q. Now, can you take all that data, aggregate it or group it and make observations about the onset of the disease in the group as a whole, like how old, what the mean, median, mode age was for onset of that disease? Can you make those kinds of observations about the data?

A. As -- again, this is in the form of a question relative to your question. So many of them got them at age X and so many of them got it at five years older and so many got it at five years older and so forth?

Q. Right.

A. Is that question?

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Q. Right.
A. All right. Now I understand that part. So, what is now the question relative to that issue?
Q. I was just wondering whether it's possible to -- to make observations about the mean, median, mode age of onset for the disease in the group?
A. I think so.
Q. Okay.
A. At least the way I understand your question so far.
Q. Okay. So, let's pretend we have a group, a population of smokers and a population of nonsmokers for which we have done that for a particular disease. It would be possible, then, wouldn't it, to compare the mean mode, median age of onset in the non-smoking group versus the smoking group? Isn't that true?
A. Well, that seems right at the moment.
Q. Okay. Well, do you know for any particular disease whether that's been done and whether the smoking group has been determined to have an earlier average onset for the disease than the nonsmoking group for any particular disease?
A. Well, I can't re -- just offhand I can't

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think of a particular study that would show that, but in that for this particular disease that we're using in a generic way, we're really -- again, we're talking about smokers and nonsmokers and what I've testified before is that smoking is a known risk factor. So -- for the diseases we've been talking about. So, at least right now, I can't think of any reason why it might not be the case that populations of that nature might have an earlier onset of --

Q. Populations of what nature? I've lost you.

A. The nature we're talking about. People who smoke.

Q. Smoking populations?

A. Smokers. That they might have an earlier onset than people who don't smoke, but that's because that they are engaging in a risk factor type behavior.

Q. Are you familiar with any studies that show that smokers have an earlier onset for particular diseases than nonsmokers?

A. I couldn't quote you one right off, no. And there may well be studies of that nature and I may well have read them, but I -- I guess I really have never focused on age of onset as something that

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I have made particular note of.

Q. Okay. So, do you know, then, whether any -- do you know of any diseases for which that finding has been made, that smokers have an earlier onset than nonsmokers?

A. I can't -- I couldn't quote you a study where I recall specifically reading that for -- as I've just discussed. That wouldn't have been an issue that would necessarily have caught my eye that I would continue to recall.

Q. Okay.

A. I just don't recall right this minute.

Q. Okay. Essentially, I have the same question, but instead of earlier onset, I'm interested in higher mortality. Do you know of any studies which compare smokers and nonsmokers which find that smokers have a higher mortality for any particular disease -- from any particular disease than nonsmokers?

A. Again, so that there's no misunderstanding about what we're talking about, if you're talking about a statistical analysis of a population, then -- some of whom smoke and some of whom don't, and smoking is a risk factor for certain diseases, some of which -- some of the -- and some of

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those diseases lead to death, then, yes, there are studies that show a higher mortality for people who engage in the risk factor of smoking compared to those who don't.

Q. For what diseases?

A. Well, for cancer and --

Q. Lung cancer?

A. Yes, lung cancer and cardiovascular disease.

Q. Okay.

THE VIDEOGRAPHER: Just about a minute.

MS. WAGNER: Okay. Why don't we go ahead and switch now.

THE VIDEOGRAPHER: This is the end of Tape Number 2. It's 2:42 p.m. We're off the record.

(Discussion off the record.)

THE VIDEOGRAPHER: This is Tape Number 3. It's 2:46 p.m. We're on the record.

Q. (By Ms. Wagner) Dr. Stiles, do the nursing homes that we discussed earlier where you've practiced, do they allow smoking?

A. Yes. At least -- I believe the entire

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time I practiced, as I recall, they had.

Q. Okay. Do you recall what the prevalence was among your patients in the nursing homes, the smoking prevalence?

A. I would have no -- I'd have no data whatsoever on that.

Q. You've never seen any data? Have you seen any data, any national data on what the smoking prevalence is among nursing home populations?

A. I don't believe so. Not that I recall. I don't believe such data exists.

Q. Any state data?

A. Not that I can recall right now. I'd want to think about that to be sure, but I -- I don't recall any data either way relative to smoking in the nursing homes right now.

Q. So, you haven't seen any data of that kind with respect to the Oklahoma nursing home population; is that right?

A. Not that I recall.

Q. Okay. Could you make an educated estimate about the smoking prevalence within nursing homes in your experience -- in your experience?

A. Really -- I really couldn't.

Q. Okay.

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A. There were -- there were residents who smoked, but I would have no idea regarding the numbers. I would think that it would be -- of the residents who were in most homes the absolute numbers or percentages of those there who were current smokers would be a minority.

Q. Minority?

A. And many times the data relative to prior smoking is just not known.

Q. Do you smoke?

A. I do not.

Q. Have you ever smoked?

A. I have not.

Q. Do you have children?

A. I do.

Q. How many?

A. Two children.

Q. What are their ages?

A. 34 and 30.

Q. 34 and 33?

A. 30.

Q. 30.

Do they smoke?

A. They do not.

Q. Have they ever smoked?

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A. I -- my daughter smoked for off and on periods in her college and shortly thereafter years.

Q. Did you advise her to quit?

A. I -- probably not.

Q. Was that because of reverse psychology?

A. During the years that she smoked she was of an age where such advice, along with most other advice, would probably not have been well received.

Q. Okay. Is smoking addictive, in your opinion?

A. Well, that's an interesting question. Addiction has many connotations. It's been defined by many different people and organizations in different ways.

In my opinion, a better term for smoking is habituation than addiction.

Q. So, you think smoking -- you believe that smoking is habituating?

A. Yes.

Q. What do you mean by that?

A. Well, for example, an addicting drug, the individual tends to be obsessed or compulsed or act compulsively in terms of obtaining the drug at almost any cost. A person who is habituated has a desire for the drug, but it's not a compulsion or obsession

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and certainly they're -- they won't go to all limits to obtain the drug.

In addiction there tends to be a progressive dose that they tend to seek greater and higher doses of the drug, and for the most part, that's not the case with smoking. With addicting drugs there tends to be a psychological dependence as well as a physical dependence and withdrawal of the drug tends to lead to significant, sometimes serious, ill effects upon the withdrawal. And with smoking there may be some psychological symptoms associated with its withdrawal, but it's a whole different order of magnitude as opposed to an addicting drug. And there may be some minor physical symptoms associated with withdrawal, but again, it's a whole different order of magnitude.

And with an addicting drug, there tends to be -- there may be adverse effects associated with its use on both the individual and on society. And with habituating drugs, if there are any effects that are -- have been associated with that behavior as having an ill effect, those tend to be restricted to the individual in general, not to society at large.

Those are the basic tenets, perhaps not all entirely stated with absolute faithfulness to

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what was said, but that's pretty much what the World Health Organization has used as a definition and a differentiation between addiction and habituation.

Q. Is that what you rely upon for your testimony about this, the World Health Organization?

A. I wouldn't say that I rely upon it. I would say that familiarity with that definition is useful and helpful, informative, and makes sense to me. It fits with my experience with people who smoke.

Q. What are the psychological symptoms associated with the withdrawal from nicotine?

A. Well, based on my experience primarily, it would be symptoms of, I guess, agitation would be a good descriptor, certain nervousness.

Q. And is that based upon your clinical experience with patients or what is -- what is the basis for that assumption?

A. As I said, that would be based primarily upon my experience of hearing people talk about what they experienced when they --

Q. People --

A. -- when they had attempted to stop smoking.

Q. People including your patients?

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A. People including my patients.

Q. Any other psychological symptoms you can think of besides agitation and nervousness?

A. I think those would be the predominant ones. As I -- just as we're thinking about it here, it seems like maybe there were a few patients who felt to be sort of depressed.

Q. What are the physical symptoms associated with withdrawal from nicotine?

A. Again, basing my response primarily on what patients and people in general have said, I would say fidgetiness, to use perhaps a non-scientific but understood descriptor.

Q. Is that different from agitation?

A. Well, I think the agitation would be a -- more of a feeling --

Q. I don't know how to spell that.

A. -- more of a feeling --

Q. Okay.

A. -- and fidgetiness would be more of an action. Restlessness perhaps.

Q. Okay. Anything else?

A. I'm not sure whether to classify it as a psychological or a physical, but in general there is a tendency to eat more.

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Q. Uh-huh. So, increased appetite, would that --

A. Yes.

Q. Okay. To your knowledge, does nicotine withdrawal have any effect on concentration?

A. I don't recall patients complaining of that, but I can see where perhaps that could be the case.

Q. You haven't read anything about that?

A. Not that I recall.

Q. Do you know whether --

A. But if they were --

Q. Oh.

A. Sorry.

Q. That's okay.

A. Continuing on, if they were anxious and restless, I can see where accompanying that might be a problem with concentration and I can see how they might complain or state to me more the problem of the nervousness as opposed to recognizing the difficulty with concentration.

Q. Uh-huh. Do you know whether nicotine has any effect on the brain?

A. Well, it must have some effect on the brain.

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Q. What do you base that on?

A. Otherwise, I don't know why people would desire or have the desire to smoke. It must give some type of psychological stimulus.

Q. Some kind of central nervous system stimulus?

A. Must be.

Q. Do you know whether nicotine can permanently alter brain chemistry?

A. I don't believe I know the answer to that.

Q. Let me turn to your disclosure for a minute. Are all the documents upon which you intend to rely in your testimony in this case included in Exhibit 2 in the list?

You want to look at it?

A. Uh-huh.

In answer to your question, let me just qualify, if I can, a little bit about your use of the word "rely."

Q. Okay.

A. These are articles and documents which I have found to be helpful, useful and informative. There are portions of these articles which have been more so than others and I am sure that there are --

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there are undoubtedly statements in these with which I would not be in complete agreement. There may well be statements in some of these documents that I would want to consider at length before I would decide that I agreed with it.

And I -- I understand that the word "rely" carries some kind of legal connotation that I don't really appreciate.

With all of that having been said, these are documents that I have found at least some portion that was useful and helpful and informative. If that comports, given all the others that I have said, with your word "rely," then I guess the answer would be yes, but with all those qualifications.

Q. Would you say that these -- that these articles or documents listed on your disclosure generally support the testimony that you're going to give in this case?

A. I would say that there -- contained within these pages of these -- these several hundred pages of documents, there are portions of those documents, statements of those documents that are germane to and supportive of my opinion in this case. In some cases, the main thrust of the article may not really be related directly to any opinion

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that I may express in the case, but it's rather a subset, a part of what was written that I agreed with and thought was useful, helpful and informative to my opinion.

Q. Are there any other documents not contained on this list which inform or support your opinion in this case?

A. Well, sure. There are -- there are -- there are lots of other sources of data that are useful, helpful and informative which I have read which I tend to agree with or don't tend to agree with which undoubtedly have an influencing -- constructing influence on my opinion in this case. That would involve listing almost everything that I have ever read in my lifetime that has to do with the issues that we're discussing today, which obviously is not a practical solution to the problem.

So, there are other articles that I have found helpful, useful and informative. These are some that I have selected.

Q. You have selected these?

A. I have selected to include in this -- now, I didn't -- I was not the originator of all of these documents, and by "originator" I mean I did not independently find each of these documents, but I

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have found that each of these documents here is germane to what my opinion is in this case.

Q. Are there other documents not on this list that are more germane or as germane?

A. There may well be other articles that express similar sentiments to some of the sentiments expressed in these articles and those might be from well-respected journals and I might well agree with them, and there might be no particular basis for selecting one of these as opposed to that one. It's just that as a practical matter, you can't list everything that you've ever read on these matters.

Q. Are there any with -- setting aside those articles not on this list that have -- that basically come to the same conclusions or support the same sentiments, as you said, are there any that support different conclusions or different sentiments that you will present as your conclusions and sentiments that aren't on this list?

A. I kind of lost you in the train there.

THE WITNESS: Could you read that back?

(The following was read by the Reporter: "Question: Setting aside those articles not on this list that have --

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that basically come to the same conclusions or support the same sentiments, as you said, are there any that support different conclusions or different sentiments that you will present as your conclusions and sentiments that aren't on this list?")

A. If I understand the correction to that, the answer is no.

Q. (By Ms. Wagner) The answer is no. Okay. Without being able to use the word "rely," I was a little tongue tied there.

Who prepared this disclosure statement? I'm looking now at Exhibit 2, this seven day disclosure.

A. That was prepared jointly by the attorneys and myself.

Q. Is this -- was this -- the first draft of this prepared in connection with the Oklahoma case or the Texas case?

A. There was a disclosure statement prepared for the Texas case and my recollection is that there are portions of this which are similar.

Q. Who prepared the Texas disclosure, if you

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remember?

A. Again, it was done jointly by the attorneys and myself.

Q. What about Exhibit 1, your original expert disclosure in this case, did you prepare this?

A. This was a -- jointly prepared by the attorneys and myself, and there are portions of this that, as my recollection serves, were in some way or another part of what was in the Texas disclosure statement.

Q. Have you seen that before today? I'm referring to Exhibit 1.

A. The -- I think so. The language is so familiar that it all seems very familiar. I'm -- I'm not absolutely positive I saw it in this spacing and format, but the content of it is -- I'm very familiar with, yes.

Q. Okay. Is the same true of Exhibit 2?

And, oh, first let me ask, do you still agree with everything that's on that disclosure?

A. Yes.

Q. Okay.

A. And now what's the question about this?

Q. The question is: Have you seen that before today?

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A. Yes.

Q. And you still agree with everything asserted in that?

A. Yes.

Q. Okay. By "that" I mean Exhibit 2.

Now, we just talked about -- you said that you weren't the original generator of the list of reliance documents listed at pages 3 -- well, it looks like the pages are missing at the bottom here, but let's say 3, 4 and 5 of the seven day disclosure. Who provided those documents to you?

MR. COX: Let me object to the form of the question. It misstates the prior testimony.

A. The documents starting with number 21 through 37, those documents were provided by the attorneys. The medical -- I'll use the word "medical" in the sense that they have come from medical journals. The other documents, those other articles, have come from a combination of sources. Some of them have come from the attorneys and some of those were articles that I included on the list from my own reading.

Q. (By Ms. Wagner) Can you tell me specifically just going through the numbers which ones were not provided to you by the attorneys?

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A. I don't think I can do that by the title, no. If you would like, we can go through the articles themselves and --

Q. I don't have them with me. There are some attached. Let me ask you that. I think there are about five or so attached. Did you select those for any particular reasons to be attached to your disclosure?

Maybe -- you can feel free to look through them --

A. Yes.

Q. -- at your leisure.

A. Let me get to the start of them here.

Okay. This is number -- okay. 38 was provided by the attorneys.

40 was supplied by the attorneys.

Okay. 39 was supplied by the attorneys.

Q. 41?

A. 41 was supplied by the attorneys.

Q. That might be it.

A. Okay. And then you asked a question about those in connection with that and I don't recall what the question was.

Q. Well, my question was: Was there any reason that you selected these, if, indeed, you

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selected them, to be attached to your disclosure in this case? These four as opposed to any others on the list?

A. My --

MR. COX: You mean the disclosure that was sent to you?

MS. WAGNER: Right. Exhibit 2.

A. My -- my understanding is that that was done because of some -- there was some legal basis for doing that.

Q. (By Ms. Wagner) Oh.

A. And it had nothing to do with -- this was not a decision I made.

Q. Okay.

A. This was -- my understanding was it had to do with some legal matter about notice and so forth, and the fact that they are attached to what you received and others were not should not be interpreted as having any other meaning or relevance or importance.

Q. Okay. Fair enough.

Of the articles on your disclosure that were provided to you by the attorneys, had you read any of those articles before?

A. Well, I'm not sure. I think if I go

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through the list based on probabilities, I might could answer that question.

Q. Okay.

A. Probably not number 1.

Q. You had not read number 1?

A. I probably had not read number 1 prior to it being provided to me by the attorneys.

Q. Okay.

A. Probably not number 2.

Probably not number 3.

Probably not number 4.

I can't say about number 5. I might have. I don't -- I don't recall specifically having read it, but I might have.

Q. Was that provided to you by the attorneys or was that something you saw --

A. It was provided by the attorneys. What I'm saying is --

Q. Right. I understand.

A. -- I might have read that independently and just do not have any specific recall of that.

Q. Uh-huh.

A. Probably not number 6.

Probably not number 7, although that's possible.

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Q. Was that -- I'm sorry. Was number 7 --
A. 7.
Q. -- provided to you by the attorneys?
A. It was.
Q. And it's possible that you'd read it before?
A. Possible.
Q. Okay.
A. Number 8 was provided by the attorneys and I probably had not read that before.
Q. Okay.
A. Number 8, I almost certainly had read and I --
Q. You mean number 9? We've already done number 8.
A. I'm sorry. Yes, number 9.
Q. Okay.
A. I almost certainly had read that and I don't -- I don't remember whether they gave it to me or whether I gave it to them.
Q. Okay.
A. But I almost certainly have read that.
Q. Okay.
A. That's generally what I might read.
I probably had not read number 10 and

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that was provided by the attorneys.

Number 11 is -- definitely I would have read that and I am fairly certain that is an article that I -- that was not given to me by the attorneys.

Q. Okay.

A. Number 12 was provided me by the attorneys and I might have read that on my own. I don't -- I don't specifically recall.

Number 13, that was provided by the attorneys and I might have read that on my own, but I don't have specific recall of that.

And likewise with 14, the same answer.

15, the attorneys supplied 15 and I probably had not read that before.

And the same with 16.

And 17 was supplied by the attorneys and I -- I might -- I might have read that, although I don't recall.

And 18 was supplied by the attorneys and I -- I had -- I had probably not read that.

And the same for 19.

And number 20 is an article that I supplied.

Now, one small clarification regarding the articles that I have said --

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Q. Were provided by attorneys?

A. -- were provided by attorneys and I had not read.

Q. Oh, okay. The ones that we just went over?

A. Let me finish my statement --

Q. Okay.

A. -- and I think it would be clearer.

Q. Okay.

A. If it's not, you can ask me questions.

There are journals that provide abstracts of other journals and it is possible that some of the articles that I have said were supplied to me by the attorneys that I had not read prior to that time, when I make that statement, I'm saying I would not likely have read those in their original publication and in their entirety. I can't say one way or another whether I might not have read the abstract of some of those, as those abstracts are published in other journals and sometimes there will be letters to the editor that may make reference to other material that's in the literature. It's possible that I had had some exposure in those ways to the literature where I have just said was supplied to me by the attorneys and I had not read before. That's a true

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statement with this additional caveat, that I might have read --

Q. Okay.

A. -- something about them or I might have read an abstract or I might have read an article that made reference to some of those articles.

Q. Okay. With respect to 21 through 43, we've already determined that you received those from the attorneys. Does that -- do you know whether you had read any of those prior to receiving them from the attorneys?

A. Let me get back here.

Okay. Starting with 21 through 40 --

Q. Through the end.

A. Through 43, yes.

Q. We've already determined that the attorneys supplied those to you.

A. Yes.

Q. You've already told me that.

A. Yes.

Q. Which, if any, of these had you read before receiving them from the attorneys?

A. All right. Certainly I had not read, prior to that time, the documents numbers 21 through 37.

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Now, let me look more carefully at the others.

Q. Okay.

A. All right. 38 and 39, 40 and 41, those were supplied to me by the attorneys.

Q. Uh-huh.

A. I do not specifically recall having read them prior to that time.

Q. Uh-huh.

A. And as I mentioned, it's possible that I read an abstract or read about them or read them as referred to in something else that I did read in the manner that I've described.

Q. Uh-huh. Are you certain that you didn't read them in their entirety before they were provided to you by the attorneys?

A. Yes.

Q. Okay. And I assume that's true--

A. And then --

Q. -- of the depositions too?

A. Yeah, I was just going to say to be completion -- to complete the list, 42 and 43, I obviously have not --

Q. Okay.

A. -- read those in any way prior to their

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being supplied to me.

Q. Were all of these documents supplied to you -- which attorney, first of all, supplied these to you, these documents in your disclosure?

A. Mr. Cox or someone in his office --

Q. Okay.

A. -- sent me 21 through 37.

Q. Okay.

A. The --

Q. When was that?

A. I will judge, and it is just a judgment, probably around August.

Q. Of this year?

A. Of this year.

Q. Okay.

A. Now, let's see. You were asking when I got -- who gave -- who gave -- who gave me the others?

Q. Who gave them to you and when?

A. Yeah.

Q. Right.

A. Okay. I guess I want to qualify now -- now this question with -- I might -- I might be wrong on one or two of these and I probably could answer that question more definitely if I was looking at the

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article, but, in general, I think this is an accurate statement. I think 1 through 7 --

Q. Okay.

A. -- and 8. I'm not sure about 9. But continuing on, but not including 9, say 10. I'm not sure about 11, but include 12.

Well, I'm not -- I'm just -- I'm really not sure. I -- the majority of those articles that I've just mentioned, I think those were supplied fairly early on in 1997.

Q. In connection with the Texas case?

A. In connection with the Texas case.

Q. And do you know who would have done that, sent them to you?

A. Well, they would have come from Shook, Hardy & Bacon. Now, which attorney had the job description of directing --

Q. Okay.

A. -- someone to put those in the mail --

Q. That's fine. That's fine.

A. -- I'm not sure.

Q. That's good enough.

And, so, you think it was fairly early on after you became involved with the Texas case?

A. I think so.

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Q. Okay.

A. And then if you want -- if it's necessary for us to go, you know, article by article through that --

Q. No, that's good enough.

A. But this would be an accurate statement to say that there was -- there was originally provided several articles that are on this list --

Q. Uh-huh. Uh-huh.

A. -- and then from time to time I might receive another article or maybe two --

Q. Uh-huh.

A. -- that kind of --

Q. Uh-huh.

A. -- from time to time bits and pieces of information.

Q. Uh-huh.

A. And I'm not sure even --

Q. How many times you received packages?

A. Oh, no, I wouldn't -- it's not many.

Q. Okay.

A. I would say three or four --

Q. Three or four.

A. -- in that order of magnitude.

Q. Okay.

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A. And I'm not sure that I could -- even if we spent a lot more time on it --

Q. I don't think we need to.

A. -- I'm not sure I could identify which of those that would apply to.

Q. Okay. Just to make sure I understand your testimony, Dr. Stiles, is it true that you can't say with certainty that you had read any of these articles in their entirety before the attorneys provided them to you, with the exception of numbers 9, 11 and 20?

A. Well, I didn't keep track as I went through there. If that's the score that you came up with, I'll trust that that's your score.

Q. That's what I came up --

A. That sounds probably right.

Q. Okay. Have you ever published any articles yourself?

A. Yes.

Q. What -- sorry.

A. But let me quickly go on to say that was a long, long, long time ago.

Q. Okay.

A. Not in -- not in several dec --

Q. So, not since you finished your

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fellowship?

A. Not in several decades. No.

Q. Okay. What was the subject of the articles that you did publish, if you can remember?

A. Remarkably enough, I do remember. There was a -- I did some research on dogs.

Q. Dogs?

A. Dogs.

Q. Smoking dogs? I'm kidding.

A. These were nonsmokers, to my knowledge.

Q. Okay.

A. And it was a study involving the use of tracheostomies and the physiological changes relative to the work of breathing and the capacity of breathing that occurred before and after tracheostomies in dogs.

Q. What was that -- do you remember the journal?

A. Kansas Journal of Medicine.

Q. Is that a peer reviewed journal?

A. Yes.

Q. Do you have any other publications?

A. I believe that's the only one. There might have been one other, but I can't -- I can't remember the circumstances about that. But again,

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that would have been --

Q. Before or after --

A. -- long, long ago and while I was still in training.

Q. Okay. Were you the primary author on the dog article or --

A. Yes.

Q. Were there any secondary authors?

A. I don't remember. I suspect there were. I was the sole investigator. I did all the work. But, as in much of that type of thing, those who are sponsors and supervisors --

Q. Got their name on the paper?

A. -- got their name on the paper. But I really think that that -- that I was the sole author of that because I did all the work.

Q. Did you perform the tracheostomies on the dogs --

A. Yes.

Q. -- on the animals?

What is a tracheostomy exactly?

A. It's a -- producing a hole in the trachea --

Q. Uh-huh.

A. -- and these are necessary in some humans

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where there is either an obstruction between the trachea and the upper airway or for some reason the individual doesn't breathe properly through the upper airway even though there's not a permanent obstruction there and they need to be connected to a ventilatory support system for a variety of reasons.

But basically it's a -- producing an incision in the trachea for the purpose of inserting a tube through which then the person or in this case the dogs breathed.

Q. For which respiratory illnesses are tracheostomies performed in humans?

A. Well, I don't believe you could answer the question quite that way. Assuming -- well, as I described, first of all, there are conditions where there is a semi-permanent or permanent or at least an insufficient airway between the nose, mouth and the lungs, somewhere between the cervical area and the mouth. That's one group.

Then there are another group of patients who, for whatever reason, have developed an insufficiency of oxygenation of the blood attempting to breathe in an unassisted manner. Those people then require ventilatory assistance mechanically by means of devices, mechanical assists to help them

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breathe. And that applies to any kind of a condition in which the oxygenation of the blood is otherwise insufficient.

And there are a number of conditions where that occurs, some of which don't actually start off as the patient's problem; that is, they may come in for something that's totally unrelated to the lungs, but in the process of becoming critically ill, the lung begins to be one of usually a series of organ systems that fails --

Q. Uh-huh.

A. -- and, so, they need ventilatory support. So, it may not actually start out as a -- as a primary lung disease.

Does that answer your question?

Q. I can't remember what it was, to be quite honest, but let me go ahead and ask another one.

Does smoking -- does smoking lead to respiratory illnesses?

A. Smoking is a risk factor for certain kinds of disorders of the lungs.

Q. For -- is it a risk factor for respiratory diseases?

A. Yes.

Q. Which ones?

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A. Chronic obstructive pulmonary disease, emphysema, bronchitis, pneumonia. Smoking is a risk factor for cancer of the lung, as we've discussed. And there may be others, but that's --

Q. And other airway cancers, like laryngeal or esophageal?

A. Yes, uh-huh. Well, esophageal would not be an airway.

Q. No, it's not. You're right. Food goes down that one; right?

A. So, it is a -- smoking is a risk factor for the oral -- the oral pharynx --

Q. Okay.

A. -- and the larynx.

Q. For which of those respiratory diseases that we just named are tracheostomies sometimes performed?

A. A tracheostomy would not be performed for any of those unless there was some reason why the patient was no longer able to adequately aerate, oxygenate the blood. So, the presence or absence of these diseases would in and of themselves not be something where one would regularly or even very often perform those.

Q. Are those diseases that we listed

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progressive in nature?

A. Well, we'd have to address each one of those separately, I believe, to answer that question. For example, there's no -- pneumonia is not something that's progressive.

Q. Okay. Pneumonia is not. What about --

A. And bronchitis is not --

Q. Okay.

A. -- progressive.

Q. COPD?

A. COPD is -- COPD and emphysema can be progressive.

Q. What about the cancers, lung, laryngeal and pharyngeal?

A. Unless satisfactory therapeutic interventions are brought to bear --

Q. Uh-huh.

A. -- in those cancerous conditions, the general -- I don't like to ever say always, but the general -- so I will say the general trend in most of those cases would be towards one of progression. There may be exceptions to that. Spontaneous cures, for example.

Q. Right. So, in the patients that suffer from the ones that are progressive where that

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exception doesn't apply, that they don't get cured, at some point is -- will the patient be unable to sufficiently oxygenate the blood through breathing?

A. For -- for the -- for the cancers that we've just discussed, that would be a possible point to which they might progress. Obviously, if there was an obstruction for those with upper airway disease that did not respond to any of the therapy, then they might benefit from a tracheostomy --

Q. Okay.

A. -- to bypass the obstruction.

Q. Did any of your geriatric patients in the nursing homes have a tracheostomy?

A. I -- I don't recall specifically having such a patient. It's highly likely that I would have.

Q. Highly likely?

A. Highly likely that I would have.

Q. But you don't recall specifically?

A. But I don't -- I don't remember a specific individual.

Q. Is it highly likely that you would have had more than one?

A. Probably.

Q. More than ten?

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A. Probably in that ballpark. I mean, it could have been 20, but --

Q. Uh-huh.

A. -- it would certainly be -- it wouldn't have been hundreds. It would have been in the ten to 20 --

Q. Uh-huh.

A. -- or maybe 30. I really don't -- it wouldn't be something I would keep track of. But it would be in a -- compared to my overall practice, it would be a very small number.

Q. Uh-huh. Do you know anything about what the medical cost for performing a tracheostomy is?

A. No.

Q. Do smokers heal more slowly than nonsmokers?

A. Heal what?

Q. Well, let's start with broken bones. Do their broken bones heal more slowly than nonsmokers?

A. I don't recall ever seeing information relative to that, but that is possible because there -- smoking is a risk factor for osteoporosis. So, that would certainly make sense that the statements you have made may be true --

Q. Uh-huh.

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A. -- and I'm just not -- I haven't seen that, but that may be true.

Q. Do you know whether smokers recovery -- recover from surgery more slowly than do nonsmokers?

A. Again, I don't recall seeing that particular statement made, but that might be true. Smokers -- people who smoke -- let me say it this way: Smoking is a risk factor for if you go in the hospital, you have a risk of your hospitalization being longer, in general. Now, whether you can -- but I'd best just say I don't know the specific answer to your question relative to surgery because I'm not absolutely certain of that.

Q. But you are familiar with data that indicates that smoking is a risk factor for a longer hospital stay?

A. Yes.

MR. COX: Whenever you get a chance, I'd like to take a break.

MS. WAGNER: Okay. One more question and I can wrap this line up.

Q. (By Ms. Wagner) Do you know whether smokers recover more slowly from respiratory illnesses than nonsmokers?

A. As we speak, I'd better not say. I'm

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not -- I'm really not sure that I've seen data like that --

Q. Okay.

A. -- with that specific question.

Q. Okay.

MS. WAGNER: We can take a break now.

MR. COX: Great.

THE VIDEOGRAPHER: 3:51 p.m. We're off the record.

(Recess taken.)

THE VIDEOGRAPHER: 4:04 p.m. We're on the record.

Q. (By Ms. Wagner) Dr. Stiles, what are the reasons that people are admitted to nursing homes?

A. It's usually a combination of that they are unable to care for themselves and they have no one who is either able or willing to care for them. That's the primary way that people get into the nursing home, if they can't take care of themselves and if they have no one to take care of them.

Q. And what's the basis for that assertion?

A. The basis for that assertion is my experience of taking care of hundreds of nursing home

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patients and that is supported by the literature relative to the reasons why people go in the nursing home.

Q. The literature that's on your disclosure?

A. Yes.

Now, we can discuss that further. I don't want that to --

Q. I'll ask you a follow-up question in just a second.

A. All right. I just didn't want that to be the end of that discussion --

Q. No, it won't be. Don't worry.

A. -- as though that was the totality of my opinion relative to that matter.

Q. Right. Is that -- the opinion you've just expressed, is that just as true in Texas as it is in Oklahoma as it is in -- anywhere in the United States, to your knowledge?

A. Yes.

Q. And what -- what supports that -- your opinion about that?

A. That the literature is not state-specific kind of data. The literature is from all over the country and those are the conclusions that others have come to, that it's -- it's the -- the

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disabilities of the individual combined with whether or not there is someone who is both able and willing to care for that individual given the dysfunctions or lack of functions that have been attained.

Q. So, the national data on that issue can be extrapolated and applied to Oklahoma, to your mind?

A. Yes.

Q. Okay. And is that because there's nothing particularly unique, to your knowledge, about the Oklahoma nursing home population relative to the rest of the country?

A. I -- I suspect that every state's nursing home population may have some variation from other states in perhaps a variety of different kinds of ways, but, nevertheless, given that each state may be a little different in one way or another, what I have stated at this point still holds true.

Q. Okay. Do you know what the variations relative to the national nursing home population are, what the variations are in the Oklahoma nursing home population?

A. By -- to make sure I understand the question, what are some of the differences --

Q. Right.

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A. -- regarding --
Q. Right.
A. -- the Oklahoma nursing home population?
Q. Right.
A. Well, they're -- they tend to be somewhat younger as a group because Oklahoma tends to have more mentally retarded individuals in the nursing homes as opposed to in some other type of care situation. So, they tend to be -- have tended to be, in general, a younger population.
Q. And what's -- on what do you base that knowledge or how did you come to have that knowledge?
A. There are -- there's information to that effect in the disclosure documents.
Q. The Oklahoma-specific ones --
A. Yes.
Q. -- that are listed on here?
A. Yes.
Q. Okay. But -- are there any other differences that you -- that come to mind?
A. About the populations in nursing homes?
Q. Nursing homes in Oklahoma?
A. The population density per nursing home tends to be less. Stated in another way, the occupancy rate --

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Q. Uh-huh.

A. -- is lower in Oklahoma and there has been a tendency to have residents with lesser disabilities; that is, as measured by such things as the number of activities of daily living in which they require assistance. The population in Oklahoma tends to be lower on the scale of those measurements of disability than the national average.

Q. So, they have fewer disabilities?

A. They tend to have fewer --

Q. On average?

A. -- on average to have fewer disabilities.

Q. Can you think of any other differences?

A. There may be others, but that's all I can think of right at this minute.

Q. Okay.

A. I'd have to think about that.

Q. And those variations don't have any impact on your statement about the reasons for nursing home admissions that you gave earlier; is that true?

A. No, except for, as I've stated, Oklahoma tended to have a greater percentage of mentally retarded people --

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Q. Uh-huh.

A. -- and I guess in some ways they meet that same criteria; that is, that they had -- they were in such a condition that they didn't have a family that was willing or able to care for them.

Q. Right.

A. But it was -- in my mind, that's a little bit different group of people than those who have developed disabilities through the years.

Q. Right. Now, you said it was a combination of the disabilities of the individual combined with whether they had someone in their lives willing or able to take care of them that leads to their nursing home admission. What disabilities typically lead to nursing home admission?

A. The most common disability is dementia.

Q. And is that -- for all of these questions, if your answer with respect to the Oklahoma nursing population is different than with respect to the national nursing home population, could you make that distinction in your answer?

A. Yes.

Q. Okay. And you said the most common disability was dementia. What's dementia?

A. Dementia is cognitive impairment of

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certain capacities, such as memory, ability to perform certain motor functions, language difficulties, difficulty with the recognition of people, places and things, and difficulties in making what you might think of as executive decisions, such as proper use of the telephone or balancing your checkbook, and these are accompanied by disorders of behavior, that is, the way people act, which is a part and parcel of this loss of the aforementioned abilities, and it's then these abnormal, disruptive behaviors that become a big part of why most people are finally placed in the nursing home. And then in conjunction with that, they also have lost, to varying degrees, abilities to care for themselves as a result of their dementia. They don't know -- for example, they have difficulties with such things as bathing or even walking or toileting, incontinence, dressing themselves, and these are measured by what are called the activities of daily living and these are either they can or they can't do this or they can do it partially. You can actually assess those dysfunctions that lead to -- that they have developed which are a part and parcel of why they are in the nursing home.

And then they also have what are called

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instrumental activities in daily living and these have to do with the use of various devices in the home, such as a stove or a mixer or oven or the telephone, those sort of things. Again, those can be measured in terms of whether they can still do some of those or can't do any of them or need help with a few.

That's all a part and parcel of what's a part of dementia.

Q. Other than dementia and the accompanying behavioral disorders and diminished activities of daily living that you just described, what other disabilities lead to nursing home admission?

A. Fractures is a fairly common reason why people are placed in the home. These are usually for a shorter term type of resident and they're there for healing and rehabilitation through physical therapy and other such modalities to help them recover from the fracture.

Q. What other disabilities lead to nursing home admission?

A. Certain individuals with cancer may be placed in the nursing home. Again, they tend to be for short periods of time, as a group.

Q. Why is that?

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A. They tend to be placed in the nursing home towards the end of their course of cancer.

Q. What's the average duration or typical duration of a short-term, cancer-suffering nursing home patient?

MR. COX: Object to the form of the question in that it assumes that there is such a number.

A. "Short-term" is a relative term, so I think I could --

Q. (By Ms. Wagner) Do you want to define it for me?

A. -- on safe ground say that the majority of fracture patients and the majority of cancer patients are there for what would be termed short-term, but --

Q. Uh-huh.

A. -- there is no strict or universally agreed upon what short-term might mean.

Q. What does it mean to you?

A. It would be measured in months as opposed to years.

Q. Looking at the overall nursing home population -- again, if you need to distinguish between Oklahoma and the national population, please

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do so in your answer. Looking at the overall nursing home population, what's the average length of stay for a nursing home resident?

A. It's in the range of 30 months.

Q. 30 months?

A. Right. And that's not to be taken as an absolute number, but in that range, give or take.

Q. Would you consider that a long-term or a short-term stay?

A. That's the average stay and I would consider that a long-term.

Q. Would you consider a two-month stay a short-term stay or a long-term stay?

A. I would consider that a short-term stay.

Q. Two months? Is that about the average stay for the people suffering from fractures or cancer in nursing homes?

A. For fractures, it's closer to a month than it would be to two months.

Q. Okay.

A. I'm not certain where cancer would fall in there, but -- probably longer than a month, but it would be measured in months, not years.

Q. Longer than -- so, under 12 months?

A. Yes.

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Q. Can you estimate whether the average cancer patient's stay would be less than six months?

A. Well, I don't want to get in the game of trying to define whether it's six months or four months or three months or 12 months. I couldn't just off the top of my head go much further than what I've said. There is probably some data in the disclosure documents that would assist me, if you want me to dig that out, but it would --

Q. Well, I'm just trying to figure out because you at first said that you group cancer patients in a -- in a short-term -- you describe them as short-term stay as a group and then you said that you would consider three months -- I think you said you'd consider three months a long-term stay, while we were talking about fractures, but I don't know whether your definition of "short-term" changes with respect to the disease.

A. Well, you sort of lost me in there. For -- in general, a short-term stay --

Q. Okay.

A. -- is considered around a month.

Q. Around a month. Okay.

A. And that would definitely apply to fractures. And I think I said something along the

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lines of that, in my mind, and I believe the literature will support the fact that most people who have cancer and are in the nursing home because of their cancer, their length of stay tends to be short-term, measured in months, not years.

Q. Uh-huh. Okay.

A. I think that's what I said.

Q. Do you know whether the length of stay differs with respect to nursing home patients admitted because of fractures who are smokers versus nursing home patients admitted because of fractures who are nonsmokers? Does the length of the stay vary between those two populations, the average length of stay?

A. I don't think there's any data relative to that.

Q. Is there any data with respect to that with cancer nursing home patients?

A. I don't believe so.

Q. Now, dementia, you said that -- are these permanent residents? Basically, they check in and then they die there, the ones that suffer from dementia, that are admitted because of dementia?

A. In general, that would be accurate. There would be exceptions to that. There would be

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the patient who might be admitted at a point in time because of dementia and because there was no one at that time able and willing to care for them where at another point in time a new caregiver came on the scene and they then will be removed from the home or the same caregiver who at one point was able but unwilling may at a later time become willing. So, those people would not be, then, permanent residents of the home. But unless some condition such as that occurred, the vast majority of those people would be there permanently.

Q. The vast majority meaning? Can you put a number on that?

A. No. It would be most.

Q. 80 percent?

A. Most.

Q. Most. More than 80 percent?

A. Well, I'd want to -- I'd want to think about that. And there may be some numbers in the disclosure documents, but I would say yes, probably -- probably more than 80 would be -- if they were -- under the conditions we've described, they were admitted because of dementia, the majority of those would be in one home or another --

Q. Till they died?

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A. -- for the rest of their life.
Q. Uh-huh.
Are you familiar with something called the minimum --
A. I need to qualify that --
Q. Okay.
A. -- as I think about it, just one more -- and that is assuming that those individuals had been correctly admitted with an irreversible dementia. There are some dementias that are treatable and, of course, in those individuals that are, for whatever reason, later more correctly, precisely diagnosed as having a correctable dementia, then those individuals also would have the opportunity of leaving.
Q. Which ones are treatable?
A. Oh, examples are like B-12 deficiency, hypothyroidism.
Q. Hypo?
A. Hypothyroidism --
Q. Uh-huh.
A. -- normal pressure hydrocephalus. And there are -- there are others, but --
Q. Uh-huh.
A. So --
Q. Okay.

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A. -- they constitute a minority --
Q. Right.
A. -- because there's not a huge percentage --
Q. Right.
A. -- but I just want to be clear that --
Q. Yeah.
A. -- that's another possibility.
Q. Are you familiar with something called the minimum data set?
A. Yes.
Q. What is that?
A. It's a several-page form that has to do with queries about a nursing home resident's status condition. This form is filled out by the nursing home personnel on all residents.
Now, that -- I don't remember exactly when that document came into being, but that -- that has not been around forever. That's a -- in the nursing home -- the history of nursing homes, that's a relative new development in terms of documentation regarding patients.
Q. Is it -- is it less than ten years old?
A. It's probably more than ten years old.
Q. Is it a Medicaid requirement?

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A. It is a -- it is a governmental agency requirement. I'm not positive that it is from Medicaid specifically, but it's a -- it is a required -- it's a government agent requirement that that be completed on all residents.

Q. Have you ever completed one of those forms, an MDS form, on a resident?

A. No. That's a task that is accomplished by the nursing home personnel.

Q. And is it completed only at admission?

A. They complete that form at admission and then there are periodic reevaluations of the status of the residents and this -- the timing interval, again, it's dictated by governmental regulation.

Q. Do you know what the set periods for reevaluation are?

A. I think it's quarterly.

Q. Okay.

A. It could be every 60 days, but, I don't know, I think it's -- I think it's quarterly.

Q. What kind of information is gathered for the MDS?

A. Well, it's a several-page form, so I make no attempt --

Q. Okay.

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A. -- to be able to include everything that's on there, but it's name, address, age, date of birth, family members, that sort of background data.

Q. Uh-huh.

A. And then it's sort of about the capabilities of, the nature of, the functional capacities of, psychological capacities of the resident, and it encompasses assessments of what they can do for themselves, what they can partly do for themselves and what they require total assistance in.

For example, the kind of thing that I mentioned earlier, can they feed themselves, bathe themselves, dress themselves, go to the toilet by themselves? Are they continent or incontinent? Is it bowels and bladder or both? Do they require assistance in walking? Do they require assistance in sitting, lying, getting out of bed, getting out of a chair? I think there are some questions about eating habits.

Those are the main things I remember right now, but that's not an inclusive list that I've just listed because it is a multi -- I think it's six or eight pages long.

Q. Does it list the medical diagnoses for

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the nursing home admittee?

A. Those diagnoses are listed as a part of nursing home records. I -- I don't remember whether it's on that particular form or not. It may be. I just don't remember.

Q. But it's somewhere on the nursing home records?

A. Yes.

Q. You just don't know if it's on the MDS?

A. I'm not -- I'm not positive that it's on the MD -- it's probably on the MDS, but I don't remember that specifically.

Q. What about smoking status, former smoker, current smoker, never smoker, is that information contained on the MDS?

A. I don't believe so.

Q. You don't believe so?

A. I don't believe so.

Q. Is it somewhere else in the nursing home records?

A. I don't think so. I don't think that is information that is regularly obtained.

Q. So, if that information does exist, you aren't familiar with it?

A. I just don't remember that as a specific

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item either, A, inquired about by the MSD or the part of the --

Q. The MDS.

A. Sorry, MDS --

Q. That's okay.

A. -- or other forms that are -- that have historically been used through the years for initial assessment.

Q. Have you ever had occasion to study or analyze data relating to the smoker status of the nursing home population?

A. To -- say it again? I'm sorry. To study -- I don't believe I --

Q. Study or review or analyze that kind of data, smoker status data, of nursing home populations.

A. Yes. There are -- there are some articles in the disclosure that relate to smoking as a risk factor for admission to the nursing home and the association has found to be nonexistent, that there -- it does not -- there is no relationship between whether a person was a former smoker or not and whether they end up in the nursing home.

Q. When you say "risk factor for admission," normally I hear risk factors pertaining to disease

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end points. What do you mean by "risk factor for admission"?

A. The relative risk for a smoker going into a nursing home compared to a person who didn't smoke going into the nursing home is the same. There is no increased risk.

Q. Or there's no increased tendency for smokers to be admitted versus nonsmokers; is that what you're saying?

A. Well, there's neither. There's neither a tendency nor a risk, as far as nursing home admissions go.

Q. Do you know what percentage of nursing home residents are smokers versus -- are current smokers versus nonsmokers versus former or -- former smokers?

A. I don't believe there's any data about that.

Q. Okay. So, if there's no data about that, is it fair to say that there is no data that you've seen that compares the treatment that each of those populations receives while they're in the nursing home? And "those populations," I mean never smokers, current smokers, former smokers.

A. What do you mean, "treatment"? I don't

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quite --

Q. The treatment that -- the medical treatment that's rendered to them while they're in the nursing home.

A. So, is the question: As populations in a nursing home, a population of smokers, prior smokers and nonsmokers, do they receive different kinds of treatment in the nursing home? Is that the question?

Q. Uh-huh.

A. Stated that way, I believe the answer would be no, I don't believe there's any data about that that they --

Q. You haven't seen any data about that?

A. I don't believe so.

Q. You said the Oklahoma smoke -- sorry -- the Oklahoma nursing home population was younger on -- was younger than the national average. What's the average age of a -- what's the national average for age of nursing home residents?

A. Well, I'll -- there's some data about that in the disclosure documents and I can look that up, to be more accurate, but it's in the seventies.

Q. Okay. And in Oklahoma, what's the average age of nursing home --

A. And I -- I would have to look that up, I

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don't remember, but I do remember that there are several documents in the disclosure that made reference to the fact that the nursing home population in Oklahoma was younger because of the fact that there were more mentally retarded patients.

Q. You don't know how much younger?

A. I don't remember the numbers. I could look it up, but --

Q. You state in your disclosure that several studies have shown a protective effect between cigarette smoking and, I guess, some cognitive impairments in the elderly. For which -- for which impairments, cognitive impairments, or diseases is that the case, in your opinion?

A. Well, first, let me state what I have stated, rather than have you paraphrase what I've stated, and then, if I may, I'll ask you to ask me a question about that, because I couldn't keep both what you were saying as paraphrased what I've said and then I couldn't keep the question in mind as well. So, may I read what I have said and then we can -- then --

Q. Sure. I'm looking at the last sentence -- I was looking at paragraph 2 --

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A. Right.
Q. -- and trying to sum up and --
A. Rather than sum, let me just read for the record what it says.
Q. Okay.
A. "The scientific evidence on the relationship between cigarette smoking and either Alzheimer's or Parkinson's disease is still inconclusive. However, several studies have shown a negative association or protective effect between cigarette smoking and these diseases."
Now, what was the question?
Q. Okay. Which studies have found a protective effect -- first -- wait. Let me backtrack.
What do you mean by "protective effect"?
A. That is that the epidemiology studies, it has been shown that smokers as a class tend less frequently to have Alzheimer's disease or Parkinson's disease than nonsmokers.
Q. So, by "protective effect" you just mean they're more -- they're less likely to have it, not that smoking actually prevents them from getting it? Are you making a distinction there?
A. Well, it has been so-called protective

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and there is some -- or some theories have been advanced as to the fact that it, in fact, may -- there may be an active protecting effect from smoking that is -- I don't know what other word to use other than "protective" -- helpful in terms of not developing Alzheimer's disease and there are some theories about why that might hold. So, that's why the term "protective" has come about in that it seems to have a favorable effect towards not having Alzheimer's disease.

Q. What are those theories?

A. That it has to do with certain receptors in the brain, that there are a loss of certain receptors in the brain and that smoking seems to -- or the theory is may have an effect of stimulating certain brain receptors, which would be the opposite of what happens in Alzheimer's disease.

Q. Other than the studies dealing with that topic in the disclosure, what's the basis for your opinion about that assertion, that smoking has a protective effect against Alzheimer's and Parkinson's?

A. The studies are the primary basis -- the studies in the disclosure documents are the primary basis for that statement.

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Q. So, in your own clinical practice, did you make it a point to keep track of which Alzheimer's and Parkinson's disease patients were smokers and which were nonsmokers?

A. Well, as we discussed earlier, when I had the opportunity to take a history on a patient, that would be a routine question that I would ask.

Q. Uh-huh.

A. As a practical matter, in nursing home populations that data is often not available. You just don't -- you just don't know.

Q. Can't you ask?

A. A demented patient may give you an answer, but it has no reliability, and family is often not available.

Q. What about medical records that that patient had in the past?

A. Sometimes those records are available. Often they are not. Not in -- not uncommonly when records are available, what you would receive would be a brief summary, which would not include any data relative to past habits, such as smoking or family history. Often they are very attenuated records. Often you just don't have any information.

Q. Now, is that true -- are you speaking now

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about your experience in treating nursing home patients in Texas or are you talking about what's known about the Oklahoma nursing home population?

A. Well, I'm talking about certainly my experience, personal experience in Texas and I have no basis on which to think that the practices through the years relative to this issue are materially different in Oklahoma than they are in Texas. In fact, I think that's a very valid assumption, they're -- very similar throughout the land that demented patients simply can't give you an accurate history about their past and patients in a nursing home frequently have no family or their family lives in other states even.

Q. Is it possible for a patient, a nursing home patient admitted for dementia to a nursing home -- admitted to -- admitted to a nursing home for dementia, is it possible for that patient also to suffer -- to suffer from a smoking-related disease concurrently?

A. Well, let --

MR. COX: Let me object to the form of the question as to what's meant by "smoking-related disease."

A. Yeah, that --

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Q. (By Ms. Wagner) The ones that we talked about today. The ones that you classify diseases in which smoking has been identified as a risk factor for those diseases. The ones we've been discussing all day.

A. All right. Once again, I want to make perfectly clear that I'm not saying that -- in the following discussion that any causal relationship has been established between those diseases and smoking.

Now, your question, then, is: Is it possible for people who have dementia to also suffer from other medical conditions?

Q. People admitted to nursing homes because of dementia and then the rest of your sentence is --

A. All right. The people -- is it possible for people admitted to the nursing home because of dementia, is it possible for them to have other medical conditions?

Q. No, not just other medical --

A. Some of which --

Q. Okay.

A. -- might include such diseases as we have discussed off and on during the day, cancer of the lung, cardiovascular disease, chronic lung disease --

Q. Diseases for which smoking is a risk

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factor.

A. Diseases for which smoking is a risk factor.

Q. Right.

A. Yes.

Q. Okay. It's possible.

Have you seen any data on whether the nursing home population actually does suffer from diseases which have been -- for which smoking has been identified as a risk factor?

A. First, let me -- most nursing home residents have multiple diseases. I would say it would probably be the exception that had only one disease or only dementia even. And then your question was, kind of the second part of that for me was -- I didn't quite follow that.

THE WITNESS: If you could read that back. Something about studies?

(The following was read by the Reporter: "Question: Have you seen any data on whether the nursing home population actually does suffer from diseases which have been -- for which smoking has been identified as a risk factor?")

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A. Yes, there are -- there are studies showing that people in the nursing home do have diseases for which smoking is a risk factor. Yes.

Q. (By Ms. Wagner) And can you give me the prevalence for those diseases occurring in the nursing home population?

A. Not right off the top of my head I couldn't. There -- there will -- there will be some information relative to that in the numerous disclosure documents. But right off the top of my head, I would be reluctant to start trying to come up with the exact numbers.

Q. Are nursing home patients treated for whatever diseases they happen to have while they're in the nursing home?

A. Yes.

MS. WAGNER: Let me go off the record right now to save my last -- how many minutes?

THE VIDEOGRAPHER: Five.

MS. WAGNER: Five? Okay. Just to make sure I didn't miss any zinger questions.

THE VIDEOGRAPHER: 4:53 p.m. We're off the record.

(Recess taken.)

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THE VIDEOGRAPHER: 4:59 p.m. We're on the record.

Q. (By Ms. Wagner) Dr. Stiles, is smoking a risk factor for the diseases that we've talked about today to the same extent in the nursing home population as it is in the general population?

A. Well, first, I'm reluctant to -- we've talked about a lot of diseases --

Q. Uh-huh.

A. -- and some of the diseases we've talked about smoking is not a risk factor. So, I'd be reluctant to --

Q. Of the ones that we've talked about where smoking is a risk factor.

A. Let me agree with your premise by stating it this way: For the purpose of the discussion that we're now going to have, we're going to talk about smoking -- diseases wherein I have previously agreed that smoking is a risk factor.

Q. Yes. Yes.

A. All right?

Q. Uh-huh.

A. Now, with that premise --

Q. Uh-huh. You want me to restate the question?

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A. -- would you restate the question?

Q. Okay. For those diseases, is smoking a risk factor for those diseases to the same extent in the nursing home population as it is in the general population?

A. Well, first of all, I would say that we don't know the answer to that question and we don't know the answer to that question because there is so little information about smokers in the nursing home; that is, the prevalence of smoking of residents of nursing homes. So, I don't -- I don't think we know the answer to that just categorically.

But, further, there is evidence that as a risk factor in the very elderly, just as a group, not limiting it to those who are in the nursing home --

Q. Uh-huh.

A. -- just elderly, the very elderly --

Q. Uh-huh.

A. -- people 75 and older --

Q. Uh-huh.

A. -- that there is evidence that the risk factor of smoking, the relative risk is less; that is, the association is less in very elderly.

Q. How can you explain that?

A. Well, I don't know the answer to that

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question, let me say that, but it probably has much to do with the fact that, as we have discussed, in general, most diseases and certainly the diseases that we have agreed --

Q. Uh-huh.

A. -- have a relative risk to smoking are multi-factoral.

Q. Uh-huh.

A. And, so, that probably plays a major role in this diminishing of the relative risk of smoking as it relates to certain diseases.

THE VIDEOGRAPHER: We're under a minute.

MS. WAGNER: Okay.

Q. (By Ms. Wagner) On what do you base your assertion on number 9 in your opinions that there's no valid medical basis for an assumption that the smoker/nonsmoker ratio for days spent in hospitals is the same as the smoker/nonsmoker ratio for days spent in nursing homes?

A. There are documents in the disclosure that address that issue and, if you'd like, I'll be glad to dig them out and discuss them.

Q. And those form the totality for the basis of your opinion for making that statement?

MR. COX: Are we over?

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THE VIDEOGRAPHER: You've got like 30 seconds.
MS. WAGNER: Okay.
MR. COX: What was the question?
THE WITNESS: What was the question?
MS. WAGNER: Can you read it back?

(The following was read by the Reporter: "Question: And those form the totality for the basis of your opinion for making that statement?")

Q. (By Ms. Wagner) Those articles in the disclosure?
THE VIDEOGRAPHER: I'm out.
MR. COX: Are we there?
MS. WAGNER: Well, he can answer it.
MR. COX: No, he can't. Time is up. The examination is over.
MS. WAGNER: We've still got a written record. I think he can answer the final question.
MR. COX: Well, the final question was not asked until time was up, so I think we're finished with the examination.
MS. WAGNER: I think it was. I think he

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just didn't hear me, so I had to repeat it, actually, if we're going to get technical.

MR. COX: Be that as it may, the deposition is over. Time is up. And I'm not doing that to be -- well, this type of thing has been done by the other side in these situations before, so --

MS. WAGNER: Not by me it hasn't, Jim --

MR. COX: I'm not saying --

MS. WAGNER: -- and something tells me --

MR. COX: I'm not saying --

MS. WAGNER: -- that you know that I wouldn't do that.

But be that as it may, thanks for your time today, Dr. Stiles.

THE WITNESS: You've been extraordinarily courteous and --

THE VIDEOGRAPHER: 5:05 p.m. We're off the record.

(Deposition recessed.)

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I have read the foregoing testimony given by me on the date and time indicated thereon and have made all corrections deemed necessary.

_____
CHARLES MERRILL STILES, M.D.

THE STATE OF _____:

COUNTY OF _____:

BEFORE ME, _____,

on this day appeared CHARLES MERRILL STILES, M.D., who

_____a) is personally known to me, or

_____b) proved to me on the oath of _____ or

_____c) proved to me on the basis of satisfactory evidence

to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he/she executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 1998.

_____
Notary Public in and for
_____County, _____
My Commission Expires:

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THE STATE OF TEXAS :

COUNTY OF HARRIS :

I, Susan R. Goldstein Henley, a Certified Shorthand Reporter in and for the State of Texas, do hereby certify that the facts stated by me in the caption hereto are true; that the foregoing videotaped deposition of CHARLES MERRILL STILES, M.D., the witness hereinbefore named, was taken by me in machine shorthand, the said witness having been by me first duly sworn under oath, and later transcribed from machine shorthand to typewritten form by me.

I further certify that the above and foregoing deposition, as set forth in typewriting, is a full, true and correct transcript of the proceedings had at the time of taking said deposition.

I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which this deposition is taken; and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

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this 2nd day of November, 1998.

_____

Susan R. Goldstein Henley
Certified Shorthand Reporter
in and for the State of Texas
Texas CSR No. 704
Expiration Date: 12/31/98

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VIDEOTAPED DEPOSITION OF

CHARLES MERRILL STILES, M.D.

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